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PUBLIC HEALTH NURSING



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PUBLIC HEALTH NURSING

BY

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Superintendent of the Providence District Nursing Association
President of the National Organization for Public
Health Nursing, 1913 - 1916

WITH AN INTRODUCTION BY

M. ADELAIDE NUTTING

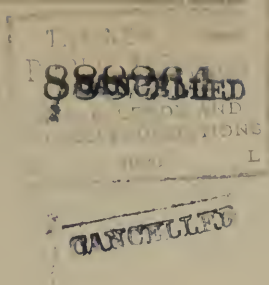
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TO THE
OFFICERS, DIRECTORS AND NURSES
OF THE
PROVIDENCE DISTRICT NURSING ASSOCIATION

PREFACE

Public health nursing is at the present time passing through a stage of such rapid development that new theories and new practices are replacing many that but a short time since were accepted as wholly desirable. This fact has been brought vividly to the writer's attention during the revision of her manuscript, the first pages of which were written three years ago. If development during the next three years proves equally rapid it is easily conceivable that much contained in these pages will be of value chiefly as showing the lines of thought leading to later conclusions.

Every effort has been made to verify facts and to give dates correctly. Much of the information has of necessity been derived from pamphlets or from magazine articles written to serve a passing need and occasionally differing in statement. When in such cases verification from an original source has been impossible the authority quoted is cited in a footnote.

Chapter I and Chapter III of Part II are revisions of articles which have appeared in the *Public Health Nurse Quarterly* under the titles "How to Organise a Visiting Nurse Association in a Small Town" and "Our Executive Officers."

No attempt has been made to make the present volume a textbook, but the writer hopes that it may prove helpful to nurses preparing themselves for public health nursing.

The writer wishes to express her appreciation and deep indebtedness to those who have rendered her valuable assistance by their advice and wise counsel — First to her brother Hon. Charles T. Davis, to Miss Ella Phillips

PREFACE

Crandall, Executive Secretary of the National Organisation for Public Health Nursing, Miss Edna L. Foley, Superintendent of the Chicago Visiting Nurse Association, Miss Ida M. Cannon, Director of the Social Service Department of the Massachusetts General Hospital, Dr. G. Alder Blumer, Superintendent of Butler Hospital, Dr. Jay Perkins, Physician in charge of the Tuberculosis Clinic of the Rhode Island Hospital, Mrs. Arthur Aldis, President of the Chicago Visiting Nurse Association, Miss Eva S. Andersen, Industrial Nurse of the South Works of the Illinois Steel Works, Miss E. F. O'Neill, General Secretary of the Providence Society for Organising Charity, Mrs. Lina Rogers Struthers, former Superintendent of School Nurses, New York, Miss Helen M. Boone, Staff Head Nurse of the Providence District Nursing Association, and especially to Miss Ada M. Carr, former Head of the Educational Department of the Boston Instructive District Nursing Association. Also to Miss Edith S. Walker for helpful secretarial assistance.

INTRODUCTION

Those who have been watching the evolution of our old friend the District Nurse through various stages into the Public Health Nurse will probably have noted how closely this growth has been identified with the sanitary and medical advances which have brought forth the modern public health movement. They will therefore have realised that the rapid expansion of health nursing is due not purely to philanthropic impulse, but that it rests upon the solid and stable ground of a well recognised and permanent social necessity.

They have probably seen how, as the public health movement has grown, it has addressed itself to the more pressing problems of the moment, concentrating its efforts first upon one menacing disease or condition and then upon another, building up machinery to be maintained for their control and ultimate prevention, and then passing on to occupy new fields of activity, and ever sweeping forward with steadily growing impetus. Thus it has devoted itself successively and continuously to the problems of tuberculosis, of the health of school children, of the study and prevention of infant mortality, of the study and prevention of insanity, of the control of venereal, of occupational, and of other diseases; and the interested observer can hardly have failed to note how at the very heart and centre of these various efforts has usually been placed the work which nurses, and they alone at present, are prepared to give. In varying capacities nurses have become an integral part of the whole public health movement, so essential and indispensable indeed to the working out of its manifold problems that it appears to be gen-

INTRODUCTION

erally understood and accepted that adequate health measures can now neither be established nor maintained without that peculiar kind of co-operation which nurses' training enables them to give. The public health movement had to forge no new instrument for this task; it found an almost perfect one, keen, flexible and potentially mighty, already available in the field. It is not a far cry from the District Nurse, working and teaching in the homes of the sick and poor and helpless, to the Public Health Nurse who reaches the home by way of the city health department, the public school, the factory or store. It is really a rational and logical step, for medical science has as yet found no better way to speak than through the voice and the personal ministrations of the visiting nurse, no more strategic point of attack than the homes in which she works, no more important factor in the spread of disease than the individuals who are the objects of her constant care and solicitude. With the behaviour of these individuals, with their hygienic conduct as it were, public health, it seems, must unceasingly concern itself.

The development and status therefore of public health nursing appear to emerge as a matter of vital public interest, and Miss Gardner has performed an important service in placing at our disposal the first really comprehensive presentation of so timely a subject. From the depths not only of a rich experience preceded by a careful training, but of an unusual understanding of, and respect for, human relationships, she brings forth the mature wisdom which characterises the book. She is wise in her counsel, wise in her suggestions, wise in her omissions.

It is not only interesting but important for us to know how this work has grown to its present coherence of effort, how it established its field, found its tools and formulated its method; what traditions have been discarded and why, and which there has seemed justification for preserving. The thousands of nurses now at work in this

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field, the older ones who have blazed their own paths, the younger ones who are just at the starting point, will greatly value these results of acute, accurate and prolonged observation; the careful analysis of typical situations in which small things are neither overlooked nor overestimated, the thoughtful discussions of the many extraordinary relationships which nurses in this work have to sustain and pass on unweakened to their successors, the clear and frequent presentation of the imperative necessity for wide co-operation with others.

Miss Gardner knows her subject from within,—every stage of it. For that, the supervisor and the staff nurse will be equally grateful. And she sees it from without as her handling of the important (and infrequently approached) subject, "The Board of Managers," admirably shows. She reveals herself as a woman of quite exceptional administrative insight. Seen through her eyes complex situations become clarified, difficulties dissolve, things settle into their places and the work moves easily to accomplishment along well-directed lines, the shaping of practical work to the fulfilling of a vision,

"With great things charged he shall not hold
Aloof till great occasion rise,
But serve, full harnessed, as of old
The days that are the destinies."

But marked as have been the recent advances in this work, and devoted as are its workers, we know that we are as yet but touching the fringe of our great public health problem. In no field in the world is the need at present greater, and nowhere is there offered a wider variety of opportunity to render services which are both greatly needed and humanly interesting and satisfying. Not only to those who have already set their hands to this urgent task, and prepared themselves to really help the world by arduous training for its service, but to the very

INTRODUCTION

large group of women of liberal education and good upbringing who are anxious to serve but not yet willing to prepare themselves to do so, should Miss Gardner's book appeal. A contribution indeed to the literature of nursing and of service has this valuable public servant of the city of Providence made.

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and Health,
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New York City.

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PUBLIC HEALTH NURSING

PART I
THE PUBLIC HEALTH NURSING
MOVEMENT

PUBLIC HEALTH NURSING

CHAPTER I

HISTORY OF THE PUBLIC HEALTH NURSING MOVEMENT

ON the foundation of a long tradition of self-sacrifice is being built the present structure of public health nursing, the latest development of modern nursing work.

Most movements are developments, not creations, but few have their roots so directly planted in a past filled with inspiration. In that past, skill, as we understand it now, was often lacking because the requisite knowledge to produce the skill did not exist, but a spirit of service was the motive power and unless that spirit remains the modern movement, with all its knowledge and all its skill, will have lost more than it will have gained.

Nursing, like so many other things the history of which may be studied from century to century, has had its ups and downs, its bright periods of inspired effort, and its black periods of temporary degradation. Because we have so lately emerged from such a black period, we do not always look beyond to what has gone before.

It is not to the Sarey Gamps and Mrs. Harrises that the ancestry of the modern nurse is to be traced. Sarey was but an unhappy incident in the history of nursing, and the ancestors of the modern nurse are the noble Abbesses and early Christian women who were trying to do for their day and generation what the nurse of to-day is trying to do for hers.

Visiting nursing, the care of the sick in their homes by those who make such work their business, has undoubtedly existed in almost all ages. When we read of the care given the sick in the centuries before Christ in such enlightened countries as India, Egypt, Greece and Rome, we cannot believe that this care was strictly confined to the hospitals. Visiting the sick is not only spoken of in the New Testament as one of the forms of charity, but long before the Christian era the Rabbis declared it to be incumbent on every Jew "to visit the sick, in order to show them sympathy, to cheer and aid and relieve them in their suffering,"¹ and since the founding of the primitive Church, such work has been a recognised part of its activity.

Deaconesses, Widows, Nuns, and Sisters all consecrated their lives to nursing work, and even from the first few centuries authentic accounts of the work of individual women come down to us. Perhaps the first visiting nurse whom we know by name was Phebe, who, St. Paul said, "hath been a succourer of many and of myself also."

With the rise of Monasticism came more concerted action for the care of the sick. Those who have visited the Benedictine Monastery founded by St. Benedict in the sixth century, perched on its hill at Monte Casino, cannot but be impressed with the many ways in which the modern settlement idea resembles this community life, with its numberless activities for the good of the people, among which nursing the sick was one of the most important.

For centuries, the monasteries and convents stood for all that was then best in nursing, and we of a later generation, who have lived to see the rise of a great secular profession, should not forget that it would have fared ill

¹ Nutting and Dock, "History of Nursing."

indeed with nursing if it had not been for the monks and nuns of the middle ages. Without the protection of the strong arm of the Church, individual effort would probably have perished in those stormy times, even if such effort could have found expression in other ways or received its inspiration from other sources.

From the Crusades sprang the military nursing orders, prominent among them the order of St. John of Jerusalem, the same order which eight centuries later in 1874 we find instituting an investigation of district nursing in England.

During the latter part of the eleventh century new nursing orders sprang up outside the Church, though later in most instances these secular orders either voluntarily or involuntarily bowed to the demands of the Church and placed themselves strictly under her control.

Nursing was an important branch of the work of the Beguines, an order which at the beginning of the fourth century is said to have numbered two hundred thousand women working in Belgium, France, Germany and Switzerland, an order which made a most determined effort to maintain its freedom, and independence of ecclesiastical control.¹

The Sisterhood of the Common Life was essentially an order of visiting nursing, while the more important order of the Sante Spirito seems to have nursed its sick in hospitals.

All through the middle ages these nursing orders existed, many of them tertiary orders, some of them for men, some for women, some for both men and women, and in them the high born and rich and those of lowly birth alike gave their services to the care of the sick. One woman of wealth and position, Mme. de Chantel

¹ Nutting and Dock, "History of Nursing."

of Digon, grandmother of Mme. de Sévigné, at first joined no order, but gave her life to visiting nursing; also taking into her own home single patients who needed her constant care. After her husband's death, with the help of St. Francis de Sâle, she founded the Visiting Nursing Order of the Visitation of Mary. The rule was most simple, involving no vows of poverty, and its members were not cloistered but were "to visit the sick daily, bathe, dress and care for them, taking home their linen to be washed."¹ Unfortunately the decree passed by the Council of Trent in 1545 that every community of women should be enclosed was a death blow to visiting nursing work as done by the religious orders. After four short years of activity, the opposition of the Church to this unenclosed community became too strong, and the rule of the order was made over and the visiting nurse work given up.

In all the past, however, there is perhaps no more prominent figure in the history of public health nursing than that of St. Vincent de Paul, who, in the middle of the seventeenth century with the help of Mlle. Le Gras founded the world-famous order of the Sisters of Charity.

A friend of Mme. de Chantel, he had seen the failure of her scheme of visiting nursing, and he was determined that the sisters should not become religious in the monastic sense,—“Nuns,” he said, “must needs have a cloister, but the Sister of Charity must go everywhere — no other monastery than the house of the sick, no other chapel than the parish church.” He knew in his wisdom that the work of a visiting nurse was incompatible with solemn vows, enclosure, hours of religious exercises and complete subordination to the clergy,¹ and he knew, too, many other things about visiting nursing. He recognised the necessity of instruction for the Sisters, and gave most excellent advice as to their relation to the physicians; while


¹ Nutting and Dock, “History of Nursing.”

his knowledge of what we now call social work was so far ahead of his time that he may be said to have really founded the first charity organisation on principles not so very unlike those accepted at the present time. His sane wise outlook and the example of his simple life of consecrated self sacrifice, together with his remarkable power of organisation, produced results too well known to require comment. Every public health nurse would do well to know by heart his beautiful description of the Sisters' calling, for it is equally applicable to our modern nurse.

"Their convent must be the houses of the sick; their cell the chamber of suffering; their chapel the parish church; their cloister the streets of the city, or the wards of hospitals; in the place of the rule which binds nuns to the one enclosure there must be the general vow of obedience; the grating through which they speak must be the fear of God; the veil which shuts out the world must be holy modesty."

We sadly need these bright spots, for in the latter part of the seventeenth century nursing entered upon the darkest period of its history. Though Sisters of Charity and Nuns were still in nominal charge of the sick in hospitals, they gave less and less personal care to the patients who were left for such care to the tender mercies of women totally unfit to bestow it.

As we read of the early history of nursing, of the work of St. Elizabeth of Hungary, of St. Catherine of Siena, of the secular orders of the Beguines and the Santo Spirito, and of the later religious orders, both Roman Catholic and Protestant, it seems almost incredible that nursing should have sunk to the level at which we find it in the middle of the nineteenth century, when modern secular nursing was brought to life by Florence Nightingale, who in turn received her impetus from the Fliedner's Training School for Deaconesses at Kaiserswert.



Even during this dark period good and devoted women were giving their lives to the relief of suffering, but it was only individual effort, and as a rule in every country the great body of the sick poor were being cared for by overworked, ignorant, and unprincipled women, while the sick rich fared but little better.

No dignity was attached to the office of nurse, and in many places the effort was not even made to obtain women of good character, as the duties were considered too disagreeable to attract the respectable. Even where nursing was nominally in the hands of Nuns and Sisters, little of the actual care of the sick was given by them personally.

This deplorable state of things was not wholly unrecognised, and there are in existence various reports published by doctors and others setting forth the situation. In one or two instances it was even arranged that some instruction should be given the hospital attendants, but no effort was made to secure the services of a higher type of woman, or to make living conditions or hours of work more reasonable.

Though nearly fifteen centuries earlier Roman ladies of patrician birth had devoted themselves to the care of the sick, and though their example has been followed at intervals throughout the history of nursing by those of wealth and social position, Florence Nightingale's assertion that nursing was a work for gentlewomen fell like a bomb upon the people of England.

Outside the protected life of the cloister this seemed impossible. The wonder to us now is that work requiring the best that any woman has to give, should have been allowed to remain so long in the hands of those totally incapable of doing it. We can hardly conceive giving our sick to the care of drunkards and profligates, but it is only by realising that this was the fate of the majority of sick people that we can comprehend what has been done for the world by the early pioneers of nursing re-

form, whose names and deeds should never be forgotten by those who follow comfortably in paths hewn out by them with such infinite effort.

Florence Nightingale's contribution is known to every one though, owing to her modesty and method of working through others, the remarkable work that she did from her sick bed during the long years of her invalidism has perhaps not always been recognised. The dramatic character of her work in the Crimea is so picturesque as to interest the whole world; but the thoughtful nurse would do well to study her later labours, for as prophetess and health teacher, she has no equal. In paying our tribute to Florence Nightingale, however, we must not forget to accord to Pastor Fliedner and to his two wives, Friederke and Caroline, the honour that is so justly their due. The seed that later grew and developed into modern secular nursing was planted at Kaiserswert and it was there that Miss Nightingale went to study nursing methods. The deaconesses nursed the sick in hospitals, in private homes and also did parish or district nursing, the training provided for them being systematic, though simple. The astonishing growth of the work of these Protestant Deaconesses all over the world proved its need at the time, though later modern nursing conditions have somewhat changed the position of Deaconesses as nurses.

Florence Nightingale did not, as many suppose, found the first school for nursing in England. Two others were established before the Nightingale School.¹ Nor was she alone in her advanced views as to the better training of nurses. Sir Edward Cook in his life of Miss Nightingale says that the reason Florence Nightingale was the founder of modern nursing was because "she made public opinion perceive, and act upon the perception, that nursing was an art and must be raised to the status of a trained profession and that the means by which she achieved this

¹ E. T. Cook, "Life of Florence Nightingale."

great work were three, by her Example, her Precept and her Practice."

We have touched upon the general nursing situation because it is necessary to realise what already existed in the middle of the nineteenth century before we can comprehend the herculean task which was undertaken by Mr. William Rathbone of Liverpool when in the year 1859 he founded with Florence Nightingale's help, the first District Nursing Association in the modern sense of the word.

He cannot, perhaps, be called the first pioneer, for in 1840 Mrs. Fry had made an effort to bring skilled care to the poor in their own homes by the establishment of the Nursing Sisters of Devonshire Square in London,¹ and in 1848 there was founded the Society of St. John's House, whose object was to raise the standard of nursing and to provide nurses for hospitals, for private cases and for the care of the sick poor in their homes.² Other Anglican Sisterhoods also included visiting nursing among their activities, though the Sisters undertaking it were usually without any adequate training for nursing work.³ The Bible Women and Nurses' Mission founded by Mrs. Ranyard in 1857 added its quota to the general effort toward the improvement of the physical condition of the poor, but nevertheless it is to Mr. Rathbone that we owe the first definitely formulated District Nursing Association, and in that sense he may be called the father of the present movement.

Owing to illness in his own family Mr. Rathbone had seen for himself the comfort brought to the sick by trained service. He therefore asked the nurse who had been in his own house to undertake as an experiment the care of

¹ E. T. Cook, "Life of Florence Nightingale."

² Amy Hughes, "History of District Nursing in England and Other Countries." Report of Jubilee Congress of District Nursing.

³ Nutting and Dock, "History of Nursing."

the sick poor in their homes for three months. The nurse consented, but at the end of one month pleaded for release from the engagement, saying that she could not endure the misery with which she was brought in contact. After persuasion however, she agreed to continue for the remaining two months, and so excellent was her report and so great her success in even this short time, that she begged to be permitted to go on, and Mr. Rathbone determined to establish a permanent system of district nursing work for Liverpool.

Miss Hughes in her address made at the Jubilee Congress of District Nursing in Liverpool in 1909 quotes from the writings of a physician showing the views held only fifty years earlier as to the possibilities of the home care of the poor.

"It's evident," writes this pessimistic gentleman, "that the essential conditions of rational and successful sick nursing, such as good air, light, warm bedding, good food, etc., are altogether wanting in the homes of the poor. Of what use are the gratuitous supply and regular giving of medicines, if every necessary is wanting for ordinary healthy living? It is not that the nurse shrinks from the privations and injurious influences existing in the cottages and hovels, but it is the impossibility of being useful under such circumstances that renders home nursing unattainable for the poor. One can comfort them, and give them food and medicine in their cottages, but to nurse and heal them there with any prospect of success cannot be done."¹

If this hopeless attitude represented general public opinion, which undoubtedly it did, those who have tried to push through some wholly new idea will appreciate the courageousness of spirit which it must have taken to launch the first District Nursing Association. Nor was the state

¹ Amy Hughes, "History of District Nursing in England and Other Countries." Report of Jubilee Congress.

of public opinion the only difficulty with which Mr. Rathbone had to contend. There were no nurses in Liverpool to do the work. One cannot imagine intrusting it to the women who were already in the nursing field, women without training, with no standards of efficiency, and in many instances without even a good moral character, to commend them.

Mr. Rathbone applied to Miss Nightingale and to Miss Jones at the Kings' College Hospital, but alas, they had no nurses to send him. Nothing daunted, this courageous Quaker erected a home for nurses on the grounds of the Liverpool Royal Infirmary, and made an arrangement by which systematic training should be given to nurses in order that they might supply the Infirmary and also give care to both poor and rich in their own homes. The care of the rich (private nursing) was only to be done however, after the needs of the Infirmary, and of the poor had been met.

That the right nurses were eventually secured, and the organisation well planned, is shown by the fact that within four years eighteen nurses were at work in Liverpool, thus effectually refuting the theories of those who agreed with the doctor whose writings have been quoted, and setting an example which has been followed all over the world.

It is significant even at this early date that the Liverpool nurses were looked upon as not mere attendants on the sick, but as social reformers, and it is also interesting that three other modern principles were recognised. The nurses must be trained nurses. They should not be almoners or dispensers of material relief. They should not interfere with the religious views of their patients. That history but repeats itself and that the early Liverpool nurses had the same sinful propensity as do their American sisters to avoid the letter of the law in regard to the rule forbidding them to be almoners, is shown by a para-

graph in Mr. Rathbone's little book, "The History and Progress of District Nursing." He comments upon the advantages of the District Homes later established, where the nurses worked under more careful supervision, and says, "The establishment of the District Homes proved an economy, as the expense of maintaining the Homes was more than balanced by the reduction in relief."

One feature of the Liverpool work, dear to the heart of its founder, has not however proved successful when transplanted to America; that is the placing of a lay woman or group of women in charge of each district, who visit with the nurse and to whom the nurse is responsible for her work in the district.

Others of the large provincial cities of England soon followed the example of Liverpool, and in 1868 the East London Nursing Association was started, but it is evident that the early principles were not always adhered to, for in 1874 we find an investigation of the system of district nursing on foot, inaugurated by the ancient order of St. John of Jerusalem, of which we have already spoken. This investigation brought to light the fact that the whole system of district nursing then existing in England was "amateur, slovenly and haphazard, and that the connection with the physician was very lax."¹

A result of this investigation was the foundation of the Metropolitan and National Nursing Association in 1875, with its great departure from previous methods in the employment only of nurses drawn from the ranks of educated women, so-called gentlewomen. This departure was apparently so revolutionary that even Florence Nightingale doubted its probable success, saying, "I don't believe you will find it answer, but try it, try it for a year."²

¹ Mrs. Dacre Craven. Paper on District Nursing, read at Congress of Charities and Corrections, Chicago, 1893.

² Amy Hughes. Paper read at International Congress of Nurses, 1901.

That it was tried, and that it did answer, reflects great credit on Mrs. Dacre Craven (Miss Florence Lees), for the standard thus set helped the whole movement wonderfully. Her own words are quoted as to her reasons for making the experiment, because the emphasis laid on the responsibilities of the district nurse can only be sharpened by later developments. "There were several reasons for this decision (to employ only educated women) and these were chiefly that in nursing the poor in their own homes, nurses were placed in positions of greater responsibility in carrying out doctors' orders than in hospitals; that women of education would be more capable of exercising such responsibility; that the vocation would attract women anxious for independent employment, and a corps of nurses recruited altogether from among educated women would have a greater influence over the patients, and by their higher social position would tend to raise the whole body of professional nurses in the consideration of the public."¹

From this time the movement spread in England until in 1887 an event occurred which, as Miss Hughes so aptly expresses it, "raised it all from the sphere of individual effort to the position of a great national institution." The determination on the part of Her Majesty Queen Victoria to devote seventy thousand pounds of the Woman's Jubilee Offering, an offering made personally to the Queen, to the furtherance of district nursing, marks an era in Public Health work. The annual income from this sum was inadequate by itself to accomplish the end in view, but a connection was made with the ancient charity of St. Katherine's Hospital, a charity founded by Queen Matilda in 1148, from which funds were forthcoming. Later through the devotion of a large sum from the amount raised at Her Majesty's Diamond Jubilee,

¹ Miss Hughes. Report of the International Congress of Nurses, 1901.

and also by private subscriptions and a commemoration offering, the demands of the Institute have been met.

The Queen Victoria's Jubilee Institute for Nurses has a dual object, the preparation of nurses for work among the sick poor in their own homes, and the extension of branches throughout the Empire.

The majority of the then already existing associations and organisations for district nursing agreed to affiliate. The central nurses' home of the new Institute was established at Bloomsbury Square at the central home of the Metropolitan and National Association, and the Institute has become a great force throughout the United Kingdom, apparently fitting its environment perfectly.

A Queen's nurse is in every instance a graduate of a hospital giving a three years' course, and in addition she receives a six months' post-graduate training in one of the homes of the Institute. She is at all times under the supervision of the Institute and receives from it both support and protection. In addition to the regular nurses of its staff the Queen's Institute through affiliation with county associations sanctions under certain conditions the employment of partially trained nurses who are known as village nurses. The qualifications of the village nurse as set forth by the Institute are as follows:—"Village nurses employed by County Associations must be certified midwives under the midwives' Act (1902) and shall have (a) if possible, twelve months, but in no case less than nine months, district and midwifery training; or (b) approved hospital training to be followed by not less than three months approved district training."¹

The conditions under which they are to work if affiliated with the Institute are also distinctly enumerated. "The Queen's Institute will only sanction the employment of village nurses (a) in a rural district where it is impossible to support a Queen's nurse and the population

¹ Queen Victoria's Jubilee Institute for Nurses. A-1.

of the district does not as a rule exceed three thousand; or (b) in a district in which a Queen's nurse is already employed and where special conditions make it desirable that a village nurse also be employed under her directions." ¹

The reason for the existence of these partially trained nurses seems to be two-fold, the inability to obtain funds for the support of fully trained nurses, and the difficulty of securing Queen's nurses willing to go to districts where the work is so restricted both in quantity and quality as not to require the full use of their powers. This latter difficulty is unaffected by the fact that the minimum salary payable to a Queen's nurse in a country district is the same as that in a town.² While no one who has been obliged to assume the responsibility of providing financially for the care of the sick in a rural or sparsely settled neighbourhood can have anything but sympathy for those who are dealing with the problem elsewhere, the danger must be recognised of any solution which involves placing the care of the sick in the hands of nurses not fully equipped to give this care. The smaller the income of the wage earner, the greater is the necessity for constant health for himself and his family, and the experience of those familiar with rural nursing in this country would point to the desirability of placing nurses of the highest possible grade in country districts, even to the point of robbing the city staffs of some of their best nurses.

We read, however, in English reports that the organisation established to furnish these nurses is satisfied with the results, and since an organisation of such irreproachable standing as the Queen's Institute, though urging the employment of a Queen's nurse whenever possible, still gives sufficient sanction to these non-graduates as to as-

¹ Queen Victoria's Jubilee Institute for Nurses. A-1.

² Twenty-fourth Annual Report Queen Victoria's Jubilee Institute for Nurses.

sume responsibility for them, we can only admit that for each country must be adopted the methods best suited to it.

There is in England also one other type of women doing district nursing, the so-called cottage nurses, who are as a rule of the same class in life as their patients, and who if needed stay in the homes, helping with the housework as well as caring for the sick. These nurses are not necessarily like village nurses, certified midwives, and their training, which is of short duration in most instances, is obtained outside the walls of a hospital.

The question of the employment in America of other than graduate nurses will be dealt with later, for it is one of great importance in the development of public health nursing.

Before turning to the United States, let us emphasise the fact that the history of public health nursing is continuous. What we are, we have become through those that have gone before, and the great leaders are of no country, but of the world. Florence Nightingale's wonderful precept and example belong no less to America than to England, and to the well-organised work of our mother country we owe a debt which, in our busy lives, we do not often enough stop to acknowledge.

CHAPTER II

HISTORY OF THE PUBLIC HEALTH NURSING MOVEMENT (CONTINUED)

IN all countries public health nursing is dependent on the status of nursing as a whole, for unless the properly trained nurse is obtainable, progress in any branch of nursing is impossible.

In America, as in England, the sick have been cared for by Nuns and Sisters, both in and out of hospitals, since the earliest settlement days. One cannot read of the hardships so heroically endured by the Sisters, in their efforts to nurse the Indians in Canada in the first half of the seventeenth century, without thrills of admiration, and at an even earlier date Spanish Nuns were at work in the hospitals of Mexico.

The Pilgrim fathers and mothers, however, were made of different material, and came to the new world for other reasons than those which brought their French and Spanish neighbours. They came to make for themselves homes, and their religion took little heed of the Indian or the state of his soul. Among the early Canadian settlers on the other hand were Jesuit priests, who came for the sole purpose of converting the savages and saw in the nursing skill of the Sisters an important means to that end.

Indeed, Montreal came into existence as a mission consisting of three communities, one of priests to manage the affairs of the colony, one of nuns to teach the faith to children, and one of Sisters to nurse the sick; and all this was arranged in obedience to what was believed to

be a direct revelation of God, before there was any colony to manage, any children to teach or any sick to nurse.¹

The newly established communities in the English colonies, however, were not long without their sick, and as the little villages grew, provision was made in hospitals. The first, Blockley in Philadelphia and Bellevue in New York, were started as what we would now call poor-houses, and dreadful indeed was their nursing history. No tales of the cruel neglect of English almshouse nursing of the same period can exceed those that can be told of these two hospitals. Lurid pictures come down to us of drunken attendants fighting like furies over the beds of their patients, or lying in sodden unconsciousness beside the bodies of the dead.

Fortunately for the sick, the past of all the early hospitals is by no means so black. The Philadelphia hospital, the first hospital in the United States in the sense of being an institution designed solely for the curative care of the sick, has a totally different record, while the Massachusetts General Hospital in Boston seems always to have been able to secure as nurses women of good character and dignified demeanour.

Training schools for nurses were a later development. It is not easy to assign to any hospital the honour of being the first to establish a training school. The New York Hospital undoubtedly made the first effort to teach its nurse attendants in 1798 and the Nurses' Society working with the Philadelphia Dispensary in 1839² gave outside instruction and training in obstetrical nursing. The Philadelphia Hospital also in 1861 opened a training school, though the first applicant did not present herself until two years later in 1863.

¹ Nutting and Dock, "History of Nursing."

² A still earlier date has been mentioned for the establishment of the work, but the early reports of the Society are incomplete. See "History of Nursing," Nutting and Dock, Vol. II, p. 345.

It was the Civil War which was destined to give the greatest impetus to nursing in the United States. Its effect was almost as far reaching as had been that of the Crimean War on English nursing. True, no great personality like that of Florence Nightingale emerged, but many women of real ability came to the fore, showing genuine executive power and doing admirable work, both as members of the Sanitary Commission and as nurses in the field. Their energies once aroused could not in the nature of things die away into inactivity, and after the war women everywhere began to interest themselves in the better care of the sick in times of peace. The result was the opening of training schools for nurses in various parts of the country.

The New England Hospital for Women and Children established its training school in 1872, the first of the modern type, and Miss Linda Richards, the first graduate, is called the first American trained nurse. Controversy has always run rife in regard to a definition of the term training school. To those students of American nursing history, who feel that the term can only be rightly applied to schools founded on what is commonly known as the "Nightingale system," the training school established at Bellevue Hospital in charge of a nurse superintendent in 1873, eight months after the New England school, has a just claim to priority. Similar schools were established in the same year at the New Haven Hospital and at the Massachusetts General Hospital.

Long before the trained nurse made her appearance, however, some efforts had been made to care for the sick poor at home.

Aside from the Sisterhoods, the first organised work of this kind seems to have been undertaken by the Ladies' Benevolent Society of Charleston, South Carolina, in 1813. This Society had a visiting committee composed of sixteen ladies, who themselves visited the sick, a certain

portion of the city being allotted to each visitor. When necessary nurses were engaged who worked under the visitors. Again it is interesting to see in this very early beginning that the danger of becoming almsgivers, rather than nurses for the sick, was recognised. The visitors "could give no money except to eight chronic cases and no more." This method of caring for the sick of Charleston seems to have worked well for fifty-two years and had it not been that the Civil War scattered its numbers undoubtedly the activity of this society, which celebrated its centennial in 1913, would have been unbroken. Indeed, the actual ministrations to the sick never did wholly cease, though no regular meetings were held for twenty years. In this country, where tradition plays all too small a part, we are glad to record the reconstruction of this old society, and the fact that in 1902 a trained nurse was engaged. The work is now being carried on according to the usual modern methods.

Undoubtedly, if we could but learn of them, there were groups of women elsewhere, who cared for the sick in some similar way, but if so, no record of these remain.

In 1849 Pastor Fliedner brought over four German deaconesses who had been trained at Kaiserswert, and established them in Pittsburg in a hospital and deaconesses' home which was in readiness for them.

It was not till 1877,¹ however, that an American organisation first systematically sent trained nurses into the homes of the sick poor, and it is to the Woman's Branch of the New York City Mission that this honour belongs.

A little later the New York Ethical Society placed nurses in dispensaries in New York, afterwards sending a nurse to Chicago to begin similar work there in 1883.

In 1885 Dr. Alfred Worcester of Waltham, Massachusetts, established a training school in which some of the ideas of Pastor Fliedner were carried out.

¹ Yssabella Waters, "Visiting Nursing in the United States."

In 1886 district nursing was organised in Boston. In the same year an Association was established in Philadelphia. In 1889, Chicago followed and in 1893 the Henry Street Settlement in New York was founded, where, in spite of its many and varied settlement activities, visiting nursing has always been the chief work.

A further chronological list of the visiting nurse associations is unnecessary. It will be more profitable to compare the beginning of the public health nursing movement in this country with that in England.

In 1890, thirteen years after the first trained nurse was sent out by the New York City Mission, there were in the United States twenty-one organisations engaged in the work of visiting nursing.¹ These organisations had no connection with one another and no common standard of efficiency either in work or in the educational requirements for the nurses. This is not surprising, for there was at this time no national association of nurses, although the association idea in other branches of work was well-organised, nor had nurses begun to take part in any of the national congresses or conventions, then common enough in lines of work closely touching their own. The first training school Alumnae Association, that of Bellevue Hospital, New York, was not formed until 1889 and the earlier efforts toward union seemed at first to only widen the distance which already separated graduates of different schools.

In the United States, therefore, each city and town was starting its visiting nurse work in its own way, and continuing in its own way with the divergence of method to be expected under such circumstances. In England, on the other hand, the newly organised Queen's Institute was setting definite standards for everything; methods of work, requirements of training, records, and uniforms

¹ Yssabella Waters, "Visiting Nursing in the United States."

even to the cut of a sleeve. As the progress made in each country has been very genuine and real, and the results from the point of view both of alleviative and preventive work differ but little, it would seem that each seed was planted in the soil best fitted for its individual growth. In America, with the formation in 1893 of the first National Nursing Association (The Society of Superintendents of Training Schools) the value of interchange of ideas was recognised, and annual conventions, national organisations, personal acquaintance and frequent correspondence have made plain the value of mutual help. Nevertheless, each public health nursing organisation in the United States has remained an individual unit, self governing in every way, and only optionally joining, if eligible, the membership of a national organisation for purposes of mutual assistance and strength.

In England, on the formation of the Queen's Institute, the great majority of the existing associations, affiliated with it, accepting from the Institute supervision of their nurses, and conforming to certain fundamental rules which govern the administration of their work.

Growth in the United States was very slow at first. We have an interesting glimpse of the situation in 1901 from the report of the Third International Congress of Nurses held in Buffalo in that year. Of the fifty-eight organisations listed as doing such work, only in twenty-two instances were the nurses working under associations founded for the sole purpose of visiting the sick. There seems to have been a strong connection with charitable organisations, twelve of the groups of nurses being employed by distinctly relief giving agencies. The hospitals are responsible for nine more, sending out pupil nurses. The remaining fifteen nurses or groups of nurses are found working under the auspices of settlements, churches, clubs, guilds, and in one instance a municipal-

ity. There were in the employ of these fifty-eight organisations about one hundred and thirty nurses.¹

From 1894, the establishment of visiting nurse associations progressed somewhat more rapidly in the United States. In 1898, Los Angeles led the way by being the first city to inaugurate municipal nursing. Not long after this appeared the first tendencies towards specialisation.

In many places special nurses had been set aside for obstetrical work, and as early as 1902 the New York Department of Health engaged nurses to care for cases of diphtheria, scarlet fever and measles. These nurses were employed for single types of cases, purely for technical reasons, in order to avoid the carrying of infection, not because of any particular hope of increased development of the specialty. 1902 and 1903, however, witnessed the rise of two special branches of public health nursing which were destined to be the forerunners of many other so-called specialties.

In 1902, after an experimental month of work provided by the Henry Street Settlement, the Municipality of New York followed the lead of England in establishing school nursing, and in 1903 the first nurse was set aside for tuberculosis work. These and other special branches of nursing will be dealt with individually in later chapters. Here it is purposed merely to trace the sequence of events, to note tendencies, and if possible to gain a little idea of future developments.

The whole question of specialisation, or as many think, over-specialisation, is an interesting one. There are now in the United States nurses specialising in school nursing, tuberculosis, infant welfare work, mental hygiene, medical social service, industrial nursing and pre-natal work, and each year new lines of work are being separated from

¹ Report of Third International Congress of Nurses, 1901.

the main body of public health nursing through the employment of special nurses.

One is tempted in explanation to make the trite remark that it is an age of specialisation. But why is it so, and is it well that we should follow the general trend and make of it an age of specialisation for public health nursing? This question is so vital, and so many and diverse opinions are held on the subject, that space will be given to a full discussion of it in a later chapter. On one side lies the danger of weakness arising from division and non-centralisation; on the other, the equal danger of loss of strength and progress that are to be gained only from concentration.

To sail between the Scylla and Charybdis of these two difficulties the public health nursing movement will need thoughtful and able seamen, on the alert to read the signs which mark the real channel.

The slow, somewhat apathetic, growth of health nursing continued until 1905. From this time development became more rapid. New associations sprang up, many more nurses were employed, and the strength of the whole movement increased in other ways than merely numerical.

As the demands upon the nurse multiplied, the question of her training became increasingly important. In the early days when the physical care of the patient presented to the majority of those who engaged her the sum total of the nurse's duties, a hospital training seemed all-sufficient.

It was the nurse herself, feeling her own limitations, proved the contrary. The nursing care of her patients led to efforts on her part to better their condition in other ways, and as she found herself unable to compass this alone, the whole field of co-operation was opened up. The moment the nurse who had behind her only a hospital training, supplemented, perhaps, by a few years of private nursing or institutional work, found herself

confronted with social problems, she was at a loss, and only gained her fullest efficiency by weeks, months and sometimes years of blundering experience. As the complexities of public health nursing grew, the truth that had been recognised from the first by the Queen's Institute in England forced itself upon those interested in the subject in America; namely, that a hospital training was not sufficient, and that a public health nurse needed special training to fit her for her work. In England no nurse is accepted on the staff of the Queen's Institute until she has added to her years of hospital training six months of post-graduate work in one of the homes of the Institute. As this has been an accepted necessity for Queen's nurses since 1888, it seems strange that in America we have been so slow to recognise a like need.

The larger associations have for years been besieged by those newly organised to send them nurses possessed of experience in visiting nursing. In spite of a very generous desire on the part of the large city associations to meet this need, and although often at great sacrifice valuable nurses have been parted with, the demand everywhere has greatly exceeded the supply.

In consequence town after town has been forced to start its work with nurses who had never done a day's district work, and the results have been as varied as the personalities of the nurses themselves. Fortunately public health nursing has as a rule appealed to a very fine type of women. Had it been otherwise, the results would have been quite different. At best, however, time has been lost while well-intentioned nurses have gained their experience through mistakes made because of ignorance of conditions which they had never before encountered.

In 1906 the Instructive District Nursing Association of Boston offered the first post-graduate course in district nursing. Since then such courses have been established in a number of other cities, Columbia University leading

the way in a recognition of the responsibility of the University for the higher education of nurses.

In addition to these post-graduate courses, hospitals in various cities send out pupils for short periods of time for visiting nursing as a part of their training. Sometimes this is done through affiliation with a visiting nursing association, sometimes directly by the hospital. The danger of this method lies in the fact that in many instances proper supervision is not furnished. Without this, both nurse and work suffer in like degree, the time spent by the pupil being practically lost, or worse than lost, and the work weakened by her natural inability to cope with problems which frequently she does not even see. In any event it is impossible to secure, in the time generally allotted, complete public health training, nor is the machinery to secure this usually existent; but looked upon as the opening of a door through which the pupil may later choose to walk, and also as a means of teaching her certain lessons difficult to learn in the hospital routine, the practice of sending out pupil nurses for district training has much to commend it. Later developments of this method may secure adequate training to the pupil, though as yet this has rarely been the case.¹ We are very far in this country from having solved the problem of the education of the public health nurse. It is something gained, however, that we are no longer satisfied with old methods. Whether the responsibility for the solution will eventually rest with the hospital training school, the college, or the public health nursing organisations, remains to be seen.

In 1909 a new aspect of public health nursing presented itself when, at the suggestion of Miss Wald of the Henry Street Settlement, the Metropolitan Life Insurance Company undertook, at first experimentally, to offer

¹ Such training is now offered by the Boston Instructive District Nursing Assn. See page 195.

home nursing to its millions of industrial policyholders in the United States and Canada. Arrangements were made, where possible, with existing visiting nurse associations to furnish this nursing, payment being based on the exact cost to the association of the visits made. A wholly new field of work was in this way opened and the value of the statistics kept by the nurses for the Company cannot fail to be of great value in the study of public health problems.

In the same year (1909) a modest experiment was first made in Brattleboro, Vermont, which has had its effect on the development of nursing services organised to meet the needs of that great body of people of moderate means who require continuous nursing care and household assistance on a paying basis. Household Nursing, the name commonly given to this type of work, implies the provision of three types of workers, graduate nurses, supervised non-graduate nurses who will perform household duties in addition to caring for the sick, and women for housework in times of illness.

Everything which affects nursing in general has naturally had an effect on the public health nursing movement. In 1901 with the first effort to secure nursing legislation in the State of New York, there began a war which will not be over till the battle has been won in each separate state of the union. The bills presented to the different legislatures have varied greatly according to local conditions and local opposition, but the effort has been everywhere the same, namely, to set and to maintain a standard to be required for the education of nurses. Where opposition has occurred it has usually been from those interested for one reason or another in lowering the standard. As state after state falls into line the day does not seem far distant when people everywhere will have the same protection in selecting a nurse, that they have long had in selecting a physician, dentist, pharmacist or plumber.

It is interesting to compare the position of the public health nurse in 1916 with that of her sister of some fourteen or fifteen years earlier. The nurse of 1916 has become one of a great army numbering over five thousand,¹ while fourteen years earlier only one hundred and thirty-six visiting nurses could by diligent search be discovered in the country.² This mere numerical increase is significant, for no factor, either for good or evil, increases at this astonishing rate without a cause.

We find the nurse of 1916 supported in these great numbers without much difficulty, because her need has been generally accepted by the community. We find other agencies counting, not only on her help in individual cases, but upon the knowledge of social conditions which she has gained from her unique position. We see that she has actually had her effect on state and city legislation, and in other instances has influenced public opinion to effect non-legislative reform. We find her valued as a preventive agent and health instructor by municipalities and state bodies, and the usefulness of her statistics acknowledged by research workers. We find her acting as probation officer, tenement house and sanitary inspector, county bailiff, domestic educator and hospital social service worker.

She is to be found in the juvenile courts and public play grounds, in the department stores and big hotels, in the schools and factories, in the houses of small wage earners and in the swarming tenements of the very poor. We find her in the big cities, the small towns, the rural districts and the lonely mountain regions. We find her dealing with tuberculosis, babies, mental cases, industrial workers and expectant mothers, midwifery and housing conditions. She instructs by means of public lectures and classes.

¹ Report of Third International Congress of Nurses.

² From data gathered by Miss Yssabella Waters.

All these things she has done, but until 1912, there was one thing she had not done. She had never associated herself with other American public health nurses in any country-wide organisation to set standards for her special work, or to strengthen it by mutual association. Such standards as existed were good, but they were set merely by the example of the stronger and better associations.

Leaders in nursing affairs had long been troubled by the situation, feeling that in the unprecedentedly rapid growth of such work lay danger, unless some method of standardisation could be devised.

In building, each stone rests upon some other stone. To the American Nurses' Association (formed in 1896 as the Associated Alumnae) and to the League for Nursing Education (formed three years earlier as the Society of Superintendents of Training Schools) the National Organisation for Public Health Nursing owes its existence. In 1911 a joint committee from these two societies was appointed to consider the question of standardisation for public health work. Letters were sent to all registered organisations employing public health nurses (1092), asking that they send to the annual nurses' convention delegates empowered to vote on the question of forming a national organisation.

The response was most encouraging. Many sent delegates, and most of those who could not, with one exception,¹ wrote of the need they personally felt for such an organisation.

The annual meetings of the American Nurses' Association and the League for Nursing Education were held in Chicago in the month of June, 1912, and there came into existence a third national body of nurses, the Na-

¹ The one exception was a small country association in an eastern state, which expressed itself as undesirous of a national association of any kind, because its nurse had been perfectly satisfactory for four years.

tional Organisation for Public Health Nursing, the purpose of which is fully expressed in its constitution as follows:

“The object of this Organisation shall be to stimulate responsibility for the health of the community by the establishment and the extension of public health nursing; to facilitate efficient co-operation between nurses, physicians, boards of trustees, and other persons interested in public health measures; to develop standards and technique in public health nursing service; to establish a central bureau for information, reference and assistance in matters pertaining to such service; and to publish periodicals or issue bulletins from time to time in the accomplishment of the general purpose of this Organisation.¹

Like the League for Nursing Education this National Organisation is an integral part of the American Nurses' Association. It differs from the two other national nurses' organisations in that it provides for lay membership, thus bringing in the great body of lay men and women engaged as directors and officers of local associations in guiding the policy of public health nursing. The need for such an organisation has been plainly demonstrated and during the four years of its existence under the able management of Miss Ella Phillips Crandall, the first Executive Secretary, the National Organisation for Public Health Nursing has played an important part in the growth and development of the public health nursing movement.

At about the same time another event of importance occurred. The American Red Cross Society decided to inaugurate a system of rural nursing not unlike that of the Victorian Order in Canada. Rural nursing in the United States has for years been a weak point, though with a few notable exceptions, such as Miss Lydia Hol-

¹ Constitution and By-Laws, National Organisation for Public Health Nursing.

man's work in the mountains of North Carolina, and others less well known. The name of this new department of the Red Cross was at first "The Rural Nursing Service," but later it was changed to "The Red Cross Town and Country Nursing Service," in order that small towns as well as the strictly rural sections of the country might consistently be included within its scope. The aim of the service is to furnish to rural districts and small towns nurses specially trained for such work, and to maintain over them a general supervision without in any way assuming local financial responsibility. Certainly the need for such work points to a wide field of usefulness and a great future for this department of our National Red Cross.

Pioneers in any new venture rarely have time to write about their efforts. For this reason, and because nurses do not as a rule turn naturally to literature as a means of self expression, we have had singularly little nursing literature, and particularly literature pertaining to public health nursing.

Since its publication in 1900 the *American Journal of Nursing* has been of inestimable value and from the beginning has given a place in its columns to visiting nursing in its various forms. In 1909 an unpretentious little magazine entitled *The Visiting Nurse Quarterly* was brought out by the Cleveland Visiting Nurse Association and was the first American publication to deal exclusively with the subject of public health nursing. On the day on which the National Organisation for Public Health Nursing came into existence the Cleveland Association presented the Quarterly to the National Organisation. Under the new title of *The Public Health Nurse Quarterly* it is having a useful career and proving the truth of the words of the German nurse, Sister Agnes Karll, who said, "Only get a nursing paper and the rest will come."

Books, too, on general and special aspects of nursing are making their appearance. No greater contribution is likely to be made than the exhaustive "History of Nursing" written by Adelaide Nutting and L. L. Dock.

Lest the impression be gained that England and the United States have a monopoly of public health nursing, at least a cursory glance should be taken at the work in other countries.

Everywhere it must necessarily be the same story. Where educational standards of nursing are low, organised public health nursing does not exist. Thus in the countries of southern Europe, we learn of no systematic care of the sick poor in their homes, while in the north such a development goes hand in hand with advancing standards of education.

¹ In Sweden, there are in one city four associations for visiting nurses, the oldest founded as early as 1888. Throughout the entire country, also, a vigorous anti-tuberculosis crusade is being carried on, in which nurses are taking an active part.

In Norway, district nursing comes within the range of the undertakings of the Norwegian Red Cross Society.

In Finland, until 1912 district work was mostly done by Deaconesses, but in that year the Finnish Nursing Association sent out its first district nurse, with the promise of more to follow.

In Holland, associations exist in Amsterdam, Haarlem and the Hague and district nursing is also done by Deaconesses.

In Germany, the older forms of the work have always been in the hands of the Church, but the newer lines, such as tuberculosis, baby work and the following up of

¹ Owing to the European war it has been impossible to obtain data regarding late developments of public health nursing in foreign countries. The following information has been obtained from "The History of Nursing" (Vol. IV), by Lavinia L. Dock, published in 1912.

alcoholics, are being undertaken by the municipalities. German nurses are also teaching hygiene in the schools and acting in the novel capacity of police assistants, while industrial nursing is likewise being undertaken. All this modern work is as yet, more or less in its infancy in Germany.

In France, the first visiting nursing in the modern sense of the word, was started in Bordeaux as an extension of the dispensary service of the Protestant Hospital. It was there also, through the influence of Dr. Anna Hamilton, that school nursing came into existence under graduate nurses. As yet, however, France has not awakened to the possibilities of public health work as undertaken by trained nurses.

In other continents, wherever English prestige exists there are as a matter of course English nurses, possessed of English nursing standards, and trying through training schools to impress them upon native pupil nurses.

In Australia, district nursing is no new thing, and recently an effort has been made to extend it beyond the limits of the towns and into the bush. This "bush nursing" corresponds to what is known with us as rural nursing, and in New Zealand the same thing is being done under the name of "back block nursing," a name quite misleading to ordinary city nurses.

In South Africa, English nurses are doing district work, while in India excellent English nursing systems exist promulgated by Florence Nightingale herself, who, not content to deal only with army problems, was intensely interested in native sanitation.

From Japan came a little Japanese nurse, to train first in the Woman's Hospital in New York, and afterwards at the Henry Street Settlement, in order that she might go back to organise visiting nursing in Japan. She writes quaintly but with undaunted courage of her difficulties. Such work can hardly fail to gain a foothold in a country

in which nursing is already making such rapid strides.

In the Philippines, where at least old prejudices and errors of nursing education do not have to be overcome, there being no nursing traditions whatever, it is interesting to note that the training is essentially a training for public health work. Young men as well as young women are being utilised, and it is hoped that the efforts of these very modern nurses will have a marked effect on tuberculosis, hook-worm disease and other scourges of the islands.

In Cuba a corps of visiting sanitary nurses constitute a special service under the Cuban Department of Health, the native Cuban nurses being excellently trained and showing unusual ability in the nursing field.

Canada has the splendid system of the Victorian Order, which is analogous to the Queen's Institute in England, and which was started in 1897 to commemorate Queen Victoria's Diamond Jubilee. This Order with its high standards (the educational standard is the same as that for the Queen's nurse) stretches across the entire continent from Halifax to Vancouver. In the far north-west tiny cottage hospitals have been established to meet the needs of that sparsely settled land. In Canada the usual forms of public health nursing, tuberculosis, industrial, school, infant welfare, and hospital social service work are undertaken as in the United States, both by municipalities and by private organisations.

In closing this slight outline of the Public Health Nursing Movement let us look for a moment at three public health nurses at work in three widely separated parts of the globe. Their heroism in doing their duty under difficulties cannot fail to be an inspiration, but an even greater inspiration lies in the thought that hardly a public health nurse exists in any land who would not as readily respond to a like call, for the spirit of service is the same in all.

First, let us have a glimpse of a Canadian nurse of the Victorian Order, sent to the Klondike in the early days. "Leaving Dawson, after the first fall of snow, she tramped twelve miles over Bonanza Trail to Grand Fork through slush and mire accompanied by the Rev. Mr. Dickey. On arriving, she was taken to the hotel to assure her a more comfortable rest after her weary tramp. She was shown into a room without any light, save from the hall, and on looking around she discovered a number of men asleep. In dismay, she went to the landlord, and told him she could not sleep there amongst those men. 'Lor', Miss,' he said, 'you will find a row of women on the other side of the floor (the men had beds) and you will find a place all ready for you, and if you will only wrap a blanket around you and leave your skirts on the stair rail, I will see that your clothes are dry by morning.' She found in the hospital, if so the miserable building could be called, ten patients, bad cases, and simply no conveniences. Pole frames over which a blanket was thrown for beds, not enough blankets to keep the patients warm, no sheets, no towels or cloth of any kind save a few flour sacks, a slop pail, a hand basin and a soap box for furniture. The basin and pail were borrowed from the butcher, perhaps the box too. Bread, bacon and rice, very little sugar, the daily bill of fare. No fresh meat, no butter or milk, the patients' food being principally boiled rice and gravy; yet they recovered. The nurse's sleeping room was the corner of a corner called by courtesy the doctor's office, and here, behind a little curtain, in an atmosphere thick with tobacco smoke, the tired nurse, rolled up in her sleeping bag, lay on the floor." ¹

The back block nursing in New Zealand presents the following picture. "One of our district nurses was summoned in the night by a lighthouse-keeper in the Sounds. His wife was in labour. At once a nurse set out, and

¹ Report of Jubilee Congress of District Nursing.

after a wild rough ride and a scramble she arrived three hours later, to find her patient almost pulseless from hemorrhage, the baby cold and almost lifeless. She set to work, and her efforts were rewarded; both mother and baby saved. Here it was an impossibility to get the doctor; he was thirty-five miles away. Immediately after the arrival of the nurse, the tide came up and the lighthouse was completely isolated.”¹

Our last illustration is of district nursing as carried on in South Africa during the siege of Kimberley. “Our brave district nurses went about their work through all the bombardment as if nothing were going on. I cannot say how miserable I felt at seeing them go out in the morning while the awful roar, shriek overhead and crash like the crack of doom, were raging outside. By God’s mercy none of them were injured, but their escapes were marvellous. Several of them were covered with dust and debris of the explosions, and all narrowly missed death by the awful hundred pounders. It was a matter of deep thanksgiving to see each one come in safely from her round, though it was only to start off again in a few hours. It was true war nursing; through the shot and shell of the siege, half starved themselves, ministering in the most hidden way among the wretched starving people of the town with the greatest patience and simplest courage.”²

¹ L. L. Dock, “History of Nursing,” Vol. IV.

² Transactions Third International Congress of Nurses.

CHAPTER III

FUNDAMENTAL PRINCIPLES

AT the bottom of any type of activity which springs more or less spontaneously into existence there will be found certain principles which are adopted as fundamental, not so much because they have worked well elsewhere, as because they are everywhere felt to be of vital importance. In addition to these basic principles, many other methods are adopted to fit varying conditions or varying periods of time. These may seem in different localities quite as important as the more fundamental principles universally adopted, and it is only by a careful study of public health work as a whole that we are able to distinguish between the two.

It is possible to consider England as well as America in looking for these fundamentals, because a number of them date back to the time when Mr. Rathbone with the farseeing assistance of Miss Nightingale founded the first district nursing association in Liverpool.

In the first place Mr. Rathbone felt from the beginning the necessity of the employment of only well-trained nurses, and this at a time when there were none to be had. Each year, as opportunity lays a greater and greater burden of responsibility upon the public health nurse, more emphasis is being placed upon this necessity.

The much quoted bishop who thanked God that there were second rate souls to be saved by second rate parsons, has his prototype in many kind hearted men and women who feel somewhat the same way about sickness. Indeed, a noble Lord, when the registration bill was under discus-

sion in England, arose and assured the house that there were two kinds of nurses required, one to nurse the people who had important operations by eminent surgeons, and another to nurse the ordinary ailments of the poor.¹ None would be so narrow as to deny the usefulness of the so-called experienced nurse who can be fitted with advantage into schemes for the care of the sick, such as those, which under the name of Household Nursing Associations are filling a real need. For public health nursing, however, in the usually accepted meaning of that term, whether in city, town or country, there is but one type of nurse, and that is the woman who has the knowledge, the experience and the discipline gained by training in a good hospital.

It is not an accident that nurses and managers, whether laymen or physicians, who have had long experience of public health nursing are quite unanimous on this point.

Lady Helen Ferguson in a paper read at the Jubilee Congress in Liverpool in 1908 speaks of "the ignorant managers who are apt to think any pleasant young person in uniform with some nursing history behind her capable of undertaking duties, the complexity of which they are not in a position to realise."²

Lady Helen has touched the real difficulty. It is not a financial question, for funds are no more easily obtained by those who feel the necessity of a trained nurse, than by those who do not. It is a question of comprehension of the duties and responsibilities of the public health nurse and if those who contemplate the inauguration of public health nursing in any of its forms will first consult those of wider experience than their own, the dangers of unstandardised work will be avoided. At present it would seem that the tendency is toward a higher, rather than a lower, standard of education, and that there is a growing

¹ Report of Jubilee Congress in Liverpool.

² Report of the Jubilee Congress in Liverpool.

demand for women who have added to their hospital training some form of special preparation for public health work.

It may be assumed, therefore, that this fundamental principle, the employment of only well-trained nurses for public health nursing, is now, as it was half a century ago, one of the foundation stones of the work.

Next, in considering principles, stress was laid on the danger of nurses becoming what the English term "almoners," dispensers of material relief. This is a principle rarely appreciated as important by the newly organised associations, but one which is universally felt to be more vital as experience progresses.

The Queen's Institute in England feels it to be so important that compliance with the general rule forbidding the nurses to be almoners, is one of the conditions on which affiliation with the Institute depends.

Of course no nurse is expected to go peacefully on caring for a patient who is suffering for the necessities of life, but she is expected to provide them through co-operation. There are two reasons for insistence on this point. In the complexity of our modern city life wise giving is a most difficult thing, and requires special social training if it is to be done with the minimum of danger to the recipient. Also it has invariably been found that the position of the nurse has been weakened if her patients look to her for material relief. Rarely is a dole of money or groceries sufficient to cure the diseases of family maladjustment or incapacity, and a thorough and expert diagnosis of the social situation is as important before treatment as a medical one. Few nurses have had the training to fit them for making such diagnosis, nor should their time be diverted from nursing, for this work, which if it is to be well done, requires many hours of many days to gain the necessary data.

Even were a nurse as well-trained a social worker as

she is a nurse, and her work allowed time for the exercise of both professions, it would still be unwise to combine the two offices, because her influence as a public health nurse would suffer. A large part of her strength in the home comes from the simple way in which she enters it, as one working woman possessed of nursing skill and knowledge who comes to place these at the disposal of another.

Her value is found first in her nursing ability, and later in her own personality, on which more and more the patient and his family learn to lean. Where material assistance is given by the nurse this simple bond seems to weaken, and the estimate of the nurse is based, not on these things, but on what she gives or what she brings.

In the city such giving is never necessary except in emergency, for by well developed co-operation all kinds of relief are possible. In the country it is sometimes more difficult to avoid, but, if done at all, it should be with the greatest reluctance, and the nurse's own personal judgment should be reinforced and clarified by that of a committee charged with the duty of such decision.

In 1849 Mr. Rathbone made a point of non-interference with the religious views of his patients, and this is an important rule of all present day associations. So much emphasis has always been laid upon this that it is rare indeed to hear of a case of proselytising by a public health nurse.

I think, however, we have not said all when we say that the nurse shall not interfere. This is merely negative. From her position in the home she can often give positive help in strengthening already existing church connections.

Broadly speaking, the three great forms of faith with which she comes in contact are the Roman Catholic, the Protestant and the Jewish. No nurse should place a Catholic child in a Protestant family, even temporarily, or send him away for a summer outing where he cannot

attend mass on Sunday without the full consent of his parish priest. It may often seem to her in individual cases that the child's physical welfare is sacrificed, but this general rule should be so well established as to admit of no exception.

Again, she should do all in her power to prevent a Catholic baby from dying unbaptised, or an older Catholic from dying without the last rites of his church. This presents a difficulty, because the announcement of the near approach of death belongs to the doctor, and if assumed by the nurse would amount to taking upon herself the responsibility of diagnosis. In many instances, however, she can confer with the physician on the subject, in case, as occasionally happens, it is not on his mind. Where death has been long expected and its immediate presence is observed first by the nurse on her daily round, few doctors will object if she suggests that the priest be sent for. The danger of arrogating to herself the sphere of the doctor, or of making the fatal mistake of unnecessarily alarming the family will be recognised by the wise nurse, and her actions guided in this matter by tact and a careful observance of professional etiquette.

The Protestant patient is often found without church connection. He has perhaps drifted away from his earlier associations, or has recently moved and failed to make himself known at the church which he has been attending, and he will gladly receive the suggestion that the nurse telephone to some minister or clergyman of his special denomination, asking that he call. The last months of many a lonely, hardened life have been quite changed because of this little effort on the nurse's part.

With the Jewish people it is more difficult, because the Jewish religious customs are hard to understand, and because they so affect the daily life of the people. A call on a Jewish Rabbi made by the nurse early in her career will sometimes save her much embarrassment in the homes

of her Jewish patients, for he will willingly explain how she may avoid trampling upon the religious feelings of the orthodox Jew. One well-meaning nurse discovered that she had transgressed no less than four times in her first half hour in the home of a good old Jewish woman to whom the religious customs of her fathers were far dearer than the life which the nurse was trying to save.

The whole question of the religious views of the patients is not a difficult one if the nurse remembers that as a public health nurse she represents not her own religious faith, but the spirit of helpfulness, which, though it may be fed by personal religious feeling, expresses itself in the effort on her part to strengthen all bonds which make for the better life of her patient.

The observance of professional etiquette was another of the fundamental principles of the early days, and by professional etiquette is meant the relation of the medical and nursing profession to public health work and to each other.

Public health nursing has had in the medical profession its greatest friend, and not infrequently its greatest stumbling block, and this seems to have been its history everywhere.

The finer and more broad-minded physician has always recognised the public health nurse as a helpmeet, who strengthens his hands, and helps him to produce results impossible alone. The poorer and narrow-minded members of the profession have regarded her with suspicion, and feared her interference at every turn. Men whose minds have been steadily fixed on the welfare of the people, not on circumstances affecting themselves, have from the first gladly given to the nurse a helping hand, and with a fine loyalty sought to strengthen her position with the patients. Men occupied chiefly with their own personal careers, who have feared that the public health nurse might jeopardise either their authority or the amount of

their work, have persistently denied her the loyalty they have so rigorously demanded for themselves.

Which influence has been stronger is shown by the growth of the work itself, for without co-operation from the medical profession such development would have been an utter impossibility. Indeed, without such aid, we can hardly conceive of the public health nurse at all.

As a matter of fact, public health nursing has increased and not decreased the work of physicians everywhere, and it is encouraging to hear from all parts of the country that former opponents are being won over, and becoming first non-combatants, and then loyal allies. This assuredly would not be the case were it not for the universal insistence on the observance of the rules of so-called professional etiquette.

In their essence, these rules are merely an affirmation of the fact that each case belongs professionally to the doctor and not to the nurse, and that a nurse, therefore, should not take upon herself duties or responsibilities rightly belonging to the physician.

In detail, they mean that she should not diagnose, should not prescribe, should not recommend a particular doctor or change of doctors, should not suggest a hospital to a patient except with the concurrence of the doctor, and should never criticise, by word or unspoken action, any member of the medical profession. While it is inevitable that in some of the large cities there must exist a certain number of inferior doctors, and that occasionally a patient must suffer from the strict observance of these rules, nevertheless, on their observance rests the whole relationship of the two professions, and if disregarded nothing but chaos can result. Imperfect nurses also exist and both professions should be considered as represented by the whole, not, as is sometimes done, by a fine representative of one as against an indifferent representative of the other,

and the general rules laid down should be independent of personality.

The nurse who is struggling with a dying baby in the hands of a physician totally uninterested in babies cannot but be rendered miserable as she thinks of the fine baby specialist round the corner. To this kind of misery, however, she must make up her mind if she is to be a public health nurse, though she need not become reconciled to it. The problem will never be solved by forcibly taking that particular baby out of the hands of that particular doctor, and placing it in the hands of the specialist. It can only be solved by the gradual education of public opinion to the point where the importance of baby work is understood.

The attitude of Florence Nightingale toward this subject is interesting. The temptation to throw aside the trammels of professional etiquette must have been great in those first awful weeks at Scutari, when the wards were overflowing with men so desperately in need of the nursing skill she had come to bring to them, yet one of her nurses says, "Miss Nightingale told us only to attend to patients in the wards of those surgeons who wished for our services, and she charged us never to do anything for the patients without the leave of the doctors."¹

It is a wise rule that a doctor shall be in attendance on every case cared for by public health nurses and it is an equally wise rule that the nurse should continue on a case only if it is his pleasure. It will usually become his pleasure if she does her work well, or if he finds that patients, as so often happens, refuse to call him unless he permits such service. In case of change of doctor, and every public health nurse is familiar with the dizzy rapidity with which such changes take place, it is her duty to put herself in immediate communication with the new doctor, and

¹ Sir E. T. Cook, "Life of Florence Nightingale."

usually it is wise to have a word on the subject with the departing one, lest she become involved in the complexities of the situation.

It will be found that in the long run real freedom for the work lies, not in a reckless independence of what may sometimes seem the unnecessarily rigid rules of professional etiquette, but in a disciplined submission to these rules which on the whole have been worked out for the greatest good of the greatest number.

Another fundamental principle of which, however, we do not hear so much in the very early days of the movement, is co-operation. Everywhere the public health nurse stands as one of the most valuable co-operating agents of the community. This has, perhaps, been a rather unexpected development of her work, but had she failed to respond to this demand and confined her usefulness to the nursing care of her patients, public health nurses would hardly have been counted by thousands, as they are to-day. Co-operation has not only done much for the patient and his family, and much towards strengthening the hands of other agencies, but it has done more than many nurses realise to relieve public health nursing itself of its most unbearable features. Many an early nurse remembers how constantly the misery she encountered haunted her off duty hours. This was largely because she was helpless to deal with it herself and did not know how to get the assistance she needed.

In order to be a good co-operator it is first necessary to know and observe a few simple rules. Unless this is done co-operation is as impossible as would be a game of whist if trumps were changed to suit the convenience of each player. True, a game played in this way might well be astonishingly successful for any one of the four individuals playing it, and in the same way a disregard of the rules of the game of co-operation will sometimes produce single results unattainable in any other way. But in

both instances it would probably be found that our independently minded friend would hardly be wanted for a second game. The well-meaning nurse who light-heartedly plays her own game, pleading ignorance and good intentions when she gets into trouble, is capable of doing more harm than can be undone by a whole staff of good nurses, and ought not to be engaged in this branch of nursing until she is better informed.

A public health nurse is not expected to do for her patients work that properly belongs to another agency, even though she may honestly believe that she is capable of doing it better. If one charitable agency is dealing with a family, that family is not to be taken from them and placed in the hands of another, even for the very good reason that number one is weak and number two is strong.

Any criticism of another agency is of course intolerable, but the nurse should go farther and should try by her helpful co-operation to strengthen the weak worker. What is technically known as "reporting back" is a valuable practice, based on the principle that a case belongs to the agency originally dealing with it, and that this agency therefore has a right to all helpful information gathered from other sources. Occasionally the nurse is puzzled as to her duty in this connection because, in her desire to be a good co-operator, she fears to betray confidence reposed in her by her patients. Each situation must be dealt with individually, but if service to the family is her watchword she cannot go far astray, and often by an honest statement of her connection with the assisting society all semblance of betrayal of confidence may be removed. As regards evidence for legal proceedings, if summoned to court as witness the nurse has no choice but to appear and tell the exact truth, as would any other citizen. Often, however, because it is undesirable that she should frequently appear in this way, it may be arranged that she shall be spared giving evidence in open

court unless it is absolutely needed for final decision, though her presence may be required through the trial. This is, undoubtedly, one of the most unpleasant duties imposed on a public health nurse, but she must comfort herself with the thought that in not a few instances the information that she possessed has alone made possible the administration of justice.

The ability to see the other person's point of view is of course the greatest help in co-operation, but inability to do so is no excuse for non-observance of the rules.

Indeed, a certain degree of lack of understanding is almost inevitable, because of the very varying angles from which every situation is approached. Each type of worker will usually be found conservative in his own line. The trained social worker sometimes seems to the impatient nurse to be straining at gnats in a painstaking effort to investigate each case, and an unwillingness to plunge into remedial measures till this is accomplished. The societies which have prosecuting powers are indigantly arraigned because in their efforts to obtain the kind of evidence termed legal, precious time seems to be lost. Such illustrations might be multiplied to cover the whole range of social work, but the nurse whose soul is tried by these things rarely stops to remember that in her own profession she herself is conservative to the last degree. Is it not probably, equally difficult for the lay mind to understand why a nurse should so persistently refuse to prescribe the simple remedy which all the world is administering at home without medical advice, or why, when it is so obviously for the best, she will do nothing about getting a sick child into the hospital merely because the foreign doctor in attendance does not like hospitals?

Occasionally criticism or a plea for greater efficiency becomes necessary, because all the social work of a community is being held back by some agency which fails to do its part. This, however, should never be done by the

nurse, but should be a matter for most careful consideration by her board of directors.

The key note of co-operation is intelligent tolerance.

Part of the value of the young public health nurse lies in the fact that she fully expects to change everything in the world that needs changing. Let her by all means keep this dynamic spirit, but let her realise that she is not going to do it at once or alone. To reach her goal she must be willing to use all the forces of her city, from the timid little volunteer with her inexperience to the worn veteran with his somewhat immobile mental attitude. She must also be willing to act without the sure hope of herself seeing the promised land. It must be enough that the promised land of municipal health exists, and that she has been privileged to lead the chosen people of her city toward it.

The importance of accurate records, which may now be accounted as one of the fundamental principles of public health work, has not always been emphasised.

In many early American visiting nurse associations, doing otherwise excellent work, a very imperfect system of record keeping existed without apparently disturbing the minds of any one. This may not have been the case in England, but at least the keeping of records was not sufficiently emphasised to be one of the points dwelt upon in early books or magazine articles.

This is explainable by the fact that in the beginning alleviative, rather than preventive, work was considered the function of the public health nurse, and any time spent away from the bedside of her patients was looked upon as of doubtful value. If records were to be kept it must be "between times," a period non-existent with the average nurse, and even had she struggled to fill out a modern history card, it is doubtful if any one would have made use of it.

With the growth of co-operation, and the increasing de-

mand for information, it became evident that the public health nurse had unusual opportunity for collecting valuable data. The tendency in every branch of work was toward a greater emphasis on accuracy, and vague statements founded on general impressions carried less and less weight.

Supporters of the work demanded figures as to results, investigators of special conditions asked permission to consult records, the nurse herself began to feel the need of a longer look backward than was possible out of her own experience if she was to take an intelligent look forward in planning her campaign.

The business connection of a majority of the visiting nurse associations with one of the large insurance companies also had its effect, for measured against the absolute accuracy of this business concern the comfortable methods of even good amateur record keeping showed in their true light.

On the whole, the public health nurse has responded more slowly to this demand than to any other made upon her, but gradually she is realising that not only accurate, but complete records are a vital part of her work, and that by keeping them she is perhaps rendering one of her most valuable services to the cause of public health.

The fundamental principle having to do with payment may be divided into two classes: first, nursing care shall be given free to those who are unable to pay for it; second, and of no less importance, those who can afford to do so shall pay according to their means.

The first part of this principle is as old as the first visiting nurse association. The second is a much later development. From the point of view of payment, patients calling upon the public health nurse may be divided into four groups: those who can make no payment; those who can make partial payment; those who can pay cost price, but can not afford a private nurse; and those who

can afford anything, but call upon the public health nurse for convenience.

In the first group are those who can save nothing from their inadequate income against the rainy day of illness. Any attempt to do so would mean such curtailment of the ordinary necessities of life as would hasten that very end. When, therefore, illness reduces or cuts off the meagre income they instantly sink below the self-supporting line, and if nursing is to be provided for them, it cannot be at their own expense. There are also always a certain number who, because of health, age, widowhood or some other handicap, never rise to the level of self-support at all, and these, too, must go without nursing if they are obliged to pay for it.

In the second group are those who can, with care, make a very slight provision for sickness, or whose income in ordinary times permits of expenditure slightly beyond the point of mere necessity, and who in times of illness, by economy at this point, can pay a small sum, perhaps from five to twenty-five cents a visit for nursing care.

In the third group belong those whose incomes are well above the line of dependency, who always expect to pay reasonable prices for everything that they obtain, and who are able to meet the expenses of illness without undue anxiety. The price, however, of a graduate nurse, resident in the house, is absolutely prohibitive, though they are well able to discriminate between her services and those of an untrained nurse. To this group also properly belong many whose outward circumstances may seem to imply a larger income because they rightly conform to a certain mode of life imposed on them by birth and tradition, but who in reality may be exercising a more rigid economy than is necessary to the small artisan or clerk. To both these elements the public health nurse, who without charity brings skilled service at a cost within their means, at the

same time teaching those in the home to give the necessary care in her absence, comes as a boon.

The fourth group, a small one, comprises the people of wealth who can well afford a trained nurse in the house, but who from the nature of the case do not require it.

That the first two groups should be cared for by the public health nurse is beyond question. For the third group all admit that some such care should be provided, and in the opinion of many such provision will always have to be made through an organisation of some sort, in order that salaries may be guaranteed and supervision furnished. So-called hourly nursing, done individually, has never been a great success.

It would hardly seem necessary that two organisations should be established in any community, one to care for those who can pay the full price for nursing care, and one to care for those who cannot. The experiment is being tried by a few visiting nurse associations of furnishing nursing care to all those requiring the ministrations of a visiting nurse; those who can afford to do so making full payment for the service.¹ Efforts are also being made through household nursing associations to meet the need of those who require more continuous care, but who are unable to afford the services of a private graduate nurse. It is becoming increasingly evident that if the public health nursing movement is to acquire its fullest development, those interested in guiding its course must be ready to enter new paths. The sick of moderate means must be cared for and at a cost which will not leave them financially crippled upon recovery.

What the future financing of public health nursing is to be, no man may say. That all such nursing should eventually be taken over by the municipality or state is conceivable. On the other hand, the growing feeling of responsibility of the employer for the health of the employed shows,

¹ See page 167 and page 206.

as does the successful experiment of an insurance company to provide nursing service for its policy holders, another tendency. Industrial or health insurance furnishes still another, and peculiarly hopeful outlook, while the increased receipts from patients, seen in almost all annual reports of visiting nurse associations, show a growing willingness on their part to make payment according to their means. Many schemes are on foot, particularly in England, to place visiting nursing on a paying basis, but in America very little has been accomplished in this way.

One fundamental principle remains forced upon us in this country somewhat at the point of the bayonet; namely, regulation of the hours of work for the nurse.

In England, where the nurses usually live in district homes, their actual hours of work are at least known. In America such homes are the exception rather than the rule, and many a nurse in her enthusiasm has prolonged her working hours far beyond the prescribed number without the knowledge or interference of her board of managers, even though the efficiency of her work and safety for herself has been obviously sacrificed. The limitation of work to the capacity of efficient accomplishment by the nursing staff is a most difficult problem, but whatever means are tried to keep pace with inevitable development, the method of allowing the nurses to undertake more than they can do well within reasonable hours is to be deprecated. Public health nursing in all its branches requires for its performance, not only a body in good physical condition, but a spirit fresh enough to be capable of enthusiasm, that mountain-moving attribute so essential for accomplishment.

Entirely apart from the fact that it is a poor example, and an anomaly, for a jaded, weary woman, or body of women, to be preaching health, it is the poorest possible economy to fail to keep the one essential tool needed for the work in good condition. It is not enough that rules

limiting the nurses' hours should be printed in every annual report. Unless such actual limitation is strictly insisted upon, against the amount of good accomplished by public health nursing, the ruined health of the worker must be placed on the debit side of the page.

These, then, may be called the eight fundamental principles of public health nursing:

1. That only well-trained nurses should be employed.
2. That the nurses should not be distributors of material relief.
3. That there should be no interference with the religious views of the patients.
4. That the rules of professional etiquette should be rigidly observed.
5. That co-operation in all its forms should be recognised as of primary importance.
6. That suitable and accurate records should be kept.
7. That patients unable to pay for nursing care should receive free service, and that those able to pay for it should do so according to their means.
8. That the daily working hours of the nurses should be limited, in order that good work may be done and they themselves be kept physically well.

This number or classification of fundamentals is by no means final. Each year brings changes and developments undreamed of in the beginning, and requiring adaptability of method and administration if progress is to be made.

The almost phenomenal increase, numerically, of the public health nurse is due to the fact that she has met a need. Her ability to meet that need, whatever it may be, will determine the future progress of the work. To do so, much more elaborate machinery will probably be required than in the days when her duties were fewer and simpler, but it must be remembered that all such machinery of organisation, local, national or international, is but a means to an end. The real object of it all is the individual.

Numbers of these individuals may for descriptive or working purposes be classed in groups, as school children, tuberculosis patients, or babies, and as such, considered as a whole; but it is only as the need of each separate individual in each group is helped to better health, either through instruction or personal ministration, that the public health nursing movement is likely to prosper.

“Large horizons,” “broad views” and “far seeing visions” are never obtained by neglect of detail, and the community whose public health nursing is not built upon the first fundamental principle of honest detail work with each man, woman, and child, though its leaders speak with the tongues of men and angels, is not only as nothing worth, but becomes a stumbling block to the true progress of the movement.

CHAPTER IV

MODERN PROBLEMS

PROBLEMS are as inevitable to a new and developing movement, as are the difficulties which beset the pioneer in a new land. In public health work, as we have seen in the last chapter, experience has gradually set experiment into the mould of custom, and old problems have ceased to exist, giving place to established principles.

Had this book been written a few years ago, we should probably have found ourselves earnestly considering the hazardous experiment of asking the patients to make payment for their care, or the risk of rendering the nurses conspicuous by placing them in uniform.

Minor problems, some of which are of local interest, others common to the work everywhere, are still constantly arising, but one by one they are being solved by those brave souls who are not afraid of the untried, and whose example is quickly followed by the less venturesome.

There are, however, three major problems which hold their heads high above the others, and which at the present moment occupy the attention of those interested in the development of the movement.

The first, concerns the education of the nurse; the second, the question of municipal or state control of the work; and the third, the growing tendency towards specialisation, with its dawning reaction. These problems and their many ramifications resolve themselves into the seemingly

simple questions, of how the nurse shall be fitted for her work, under whose authority that work shall be done, and in what way she shall do it.

The writer realises that these questions will be best answered by the knowledge that is slowly being gained by experience. Various methods of education are being evolved, municipal and state nurses are engaged in various branches of work, and special nurses and general nurses are at work all over the country. Time will inevitably show to the open-minded which methods are in the long run productive of the most satisfactory results, but as many a forked road is unheedingly passed, it may be well to point out a few of the aspects of these three problems.

That all public health nurses should be graduates of hospital training schools has in America been accepted as a foregone conclusion. Most of the more enlightened now go a step farther, and feel that the training should conform to certain requirements as to educational opportunity.

This hospital training, the essential foundation for any nurse, teaches the care of the sick patient, but up to the present time has left almost wholly untouched those social aspects of sickness and health which loom so large on the horizon of public health nursing. It is an undisputed fact that the nurse with only her hospital training behind her cannot be intrusted with the real responsibility of public health work. Either she must be placed where her work will be done under careful supervision, or else the association engaging her must pay for her inexperience by frequent blunders, or by a slowness of growth due to her inability to see and grasp opportunities.

Our grandfathers made experience do the work of training, and the school of experience has graduated many of our finest men and women. We are finding, however, that in order to be educative, the experience need not always be strictly personal. In many lines of work the experience of others is being placed at the disposal of the novice, to

the advantage of every one and with a great saving of time.

The public health nursing movement can hardly be expected to pass from a pioneer stage into a period of greater usefulness without conforming to the modern method of replacing the slow process of acquiring education through experience by some system of training which will create a standard of efficiency for its workers.

The great question at present is how to give this training, and in what it shall consist.

If the hospital training school is to be responsible, shall it be given to all nurses during their undergraduate days, shall it be given as an elective course during the third year to those who desire it; or shall a combination of the two methods be used, all pupil nurses receiving a certain grounding in the subject early in their training with more advanced work made possible later if desired?

We demand a great deal of our modern graduate nurse, and those responsible for her training find no little difficulty in sending her out from the hospital fully equipped with what is now considered necessary. Certain minimum periods of time in the various wards, operating room, diet kitchen, etc., must be arranged before the question of special branches of nursing can be considered. Those of us whose interests lie in these special branches must not forget, in our zeal to see our specialties taught, that such training can only be applied to a nurse already well-grounded in what the hospital wards alone can teach. We must have a good nurse before we can have a good obstetrical nurse, a good orthopedic nurse, or a good public health nurse. If we try to develop the latter at the expense of the former, failure will most assuredly confront us.

At a nurses' convention it is amusing, because of the repetition, to hear nurse after nurse plead that better training be given the pupil nurses in the various specialties in which each speaker is personally interested.

It is obviously impossible for the hospitals to continue to meet these ever increasing demands, and in the two or three years allowed them, to properly equip their nurses for every branch of nursing. Certain things should be taught to all nurses, irrespective of what they intend to do.¹ But why cannot the third year be made, within certain limits, elective?

We realise the great difficulty of adjustment, and we also recognise that if such a plan were adopted, a number of nurses would be sent out from their hospitals untrained for certain types of work. It could, however, be made possible for any nurse wishing later to take up a specialty for which she had not been trained, to fit herself for it by a post-graduate course.

All this would imply highly organised machinery of affiliation. But would it not also mean better service to the community, and on the whole less loss of time to the nurse? As more and more is being demanded of the public health nurse, it is already becoming increasingly necessary for her to take such a post-graduate course if she is to fit herself for efficient work, and this is often a matter of great financial difficulty for the new graduate.

Post-graduate courses in public health nursing have been offered under various conditions. They have been offered by visiting nurse associations in exchange for part time work from the student; they have been offered by visiting nurse associations in conjunction with colleges and other educational and social agencies on a paying basis; and they have been offered by colleges and universities under the same conditions. Undoubtedly at the present time the tendency is toward an assumption of the responsibility by purely educational institutions. Scholarships are in many instances available for nurses possessed of unusual qualifications, thereby making post-graduate train-

¹ See recommendations of the Committee on Public Health Nursing of National Organisation for Public Health Nursing, p. 212.

ing possible for those to whom it would otherwise be financially unattainable.

The question, what we want our public health nurse taught, is not easily answered. We want the finished product to possess so many of the attributes of perfection that, if we are to deal with ordinary human nature, compromise will have to be accepted. All are familiar with the descriptions of the necessary virtues required by those anxious to find the right woman for some form of social work, and many can sympathise with the weary headworker of a Children's Aid Society, who replied to such a request, "Madam, if I could find the woman you describe I should marry her, not pass her on to you."

One thing seems quite certain, no course or school for public health nursing is likely to turn out a nurse perfectly trained in all the branches of public health work. It can hardly be expected. What can be expected is that the graduate of such a school should possess an awakened spirit to the possibilities before her, a working knowledge of certain fundamental principles governing public health nursing, a sympathetic interest in activities not strictly her own, and perhaps, most important of all, a sufficient insight into the public health nursing movement, as a whole, to enable her to grasp correctly her own part in its work.

With all this will come the knowledge that what she herself does not know, somebody else probably does, and that through the medium of books or correspondence this knowledge may be placed at her disposal.

What we really want of our public health nurse is that wisdom which King Solomon of old considered the most precious thing in the world, and wisdom is not acquired in any short year of a woman's life. As, however, many things go into the making of a wise woman, some of them may be given to her during her training. On her power of assimilation will depend the value of such a course to

her. Courses may be so arranged as to secure for the student a general knowledge of the principles underlying all public health nursing and time also allowed for additional elective study, in case she plans to specialise in some particular line of work. Courses dealing with such subjects as the history and development of public health nursing, methods of organisation and administration of work, municipal and industrial sanitation, household economics, modern social problems, social legislation, etc., prepare the student's mind for more specialised study of tuberculosis nursing, infant welfare work, rural problems, hospital social service, industrial and mental hygiene nursing, sanitary inspection, or any of the other forms of public health work.

The relative time to be given to theoretical and practical work should be a matter for careful consideration. All are agreed that while theoretical instruction is most important, it is absolutely impossible to give practical public health training without actual experience in the homes of the patients. Also, in the opinion of many, such experience cannot take the form of mere observation of the methods of others, but to be valuable, a certain amount of responsibility must be vested in the student herself, safeguarded, of course, by wise supervision. It is the ability to carry responsibility that is so prized in a nurse entering a new field, and such ability cannot be learned in the class room alone. The growing tendency on the part of colleges and universities to recognise their opportunities and responsibilities toward nursing education, particularly toward public health nursing education, is very gratifying, but there is perhaps a possible danger in the situation which must be guarded against, as greater stress is laid upon the mental equipment of the public health nurse. The combination of hospital training and post-graduate *theory* alone will never produce a well-trained public health nurse, for no nursing work must be taught by

theory. Actual contact with the patient or the family is as essential a part of post-graduate as of undergraduate training, and the moment that theory and practical work are divorced we shall see a decline in the value of the nurse. It is undoubtedly unnecessary to sound this note of alarm, for laboratory work is duly emphasised in all college curricula. Nevertheless, in nursing education let us never cease to insist on the importance of those things which can be learned from the patient alone.

It is a truism that education of any kind fails of its true purpose unless it is considered as a starting point for further excursions into the field of knowledge. If the student's interest can be aroused in the mere existence of such problems as the family budget, the housing question, school hygiene, probation, and the many other live issues of the day, she will never be as she was before. If, in addition to her own chosen line of work, she can be given an acquaintance, gained from personal observation, with school and tuberculosis nursing, with the work of shop, factory, or hotel nurses, with hospital social service, with mental hygiene work, or with the rapidly developing field of infant welfare, door after door will have been opened to her, and the key, at least, placed in her hand for future use.

The success or failure of such education will depend on the power of the educator to give this to the student, not as a mere hodge podge of unrelated though interesting information, but as closely related aspects of one vast subject which, in turn, has its own place in the general trend of the day.

The increasing interest shown in public health nursing education makes the prospect a bright one, for in the better education of the public health nurse lies the surest hope for the future of the whole movement.

The second major problem, that of municipal or state control of public health nursing, is one affecting princi-

pally, though not exclusively, the various special branches of the work.

In the past, public health nursing has almost everywhere been started as a private enterprise. Occasionally there has been a municipal subsidy, but where this has been the case it has rarely been granted until the value of the work has been proved by private philanthropy. Even the branches of the work now usually undertaken by municipalities, such as school nursing or the care of the tuberculous, were first demonstrated as successful experiments by visiting nurse associations. There is undoubtedly at the present time a very general tendency in many directions toward an increased assumption of responsibility by both states and municipalities. Those who are opposed to all such tendencies as paternalistic naturally object to state or city control of public health nursing. Other objections are more or less involved in local political conditions, though there are certain inherent advantages and disadvantages to both public and private administration of nursing work which may be briefly mentioned.

Public health nursing as undertaken by private initiative has everywhere enlisted the interest of groups of men and women who have performed their duties as a veritable labour of love, bringing to them a spirit of devotion and self-sacrifice which is of inestimable value. The withdrawal of such a spirit from any movement could not fail to be a matter of serious concern. The loss of elasticity of methods under public administration is another, though less serious consideration, while the danger of undue political interference and the uncertainty attending the question of appropriations are more or less important difficulties as they are affected by the various local political situations.

On the other hand, the fact cannot be ignored that much good work is being retarded in its growth because of the inability of private organisations to raise the funds neces-

sary for expansion. Due and primary emphasis should be laid on the quality of public health nursing work, but the quantity of it is also a matter of importance. It is not enough that visiting nurse associations should look with satisfaction on any limited accomplishment, ignoring because of financial impotence, unopened districts or unexplored fields of endeavour. Nor is it enough that a state should point with pride to the well-developed public health activities of its large cities. What of the hundreds of square miles of farm lands or the countless small villages where no provision for nursing care is made?

If free public health nursing is a logical sequence to free public school education, and there seems no very good reason why it should not be, private enterprise must hold itself in readiness to step aside, permitting state and municipality to undertake and accomplish a task wholly beyond its own financial powers. Nothing so extreme, however, may be in store for public health nursing. It seems more likely that there will be a continuance of the present situation. Private organisations will continue to inaugurate new work and maintain old work, and municipalities will continue their responsibility for certain of the special branches, entering perhaps, new and as yet unexplored paths while the state will concern itself more and more with public health nursing in rural districts through county organisations. What part the Federal Government may eventually take in the public health nursing movement we do not know, though the establishment of the Federal Children's Bureau foreshadows a number of possibilities. That public health nursing is being efficiently done by both municipalities and state bodies is well known. Where a change of administration has been made it has not infrequently been found that some branches of the work formerly undertaken by private organisations have been distinctly strengthened by the authority of municipal control, while others placed under

the state have gained by the uniformity of effort made possible in the larger area.

The situation which exists at the present time in many cities would seem a healthy and satisfactory one; namely, the existence of a vigorous visiting nurse association supported by private funds, and in addition a staff of city nurses for school nursing, tuberculosis work, midwife inspection or any of the other branches of the work usually assumed by the municipality. The association, with its greater independence of action, can go before, inaugurating new methods, starting new specialties and setting a high standard of efficiency. When the time is ripe for separation, the various well-tried branches of the work may be turned over to the municipality in good running order, together with the nurse or nurses most familiar with their management.

In this way the private enterprise is financially freed for new efforts, and the municipality is relieved of the difficulties of the experimental stages of its work. By the exchange of nurses close co-operation is somewhat simplified, and the public health work of the city is conducted as one big and important undertaking, without overlapping or friction, and with an assurance of stability and permanency, as well as elasticity and fostering attention, derived from the dual nature of its existence.

The greatest safeguard against deterioration of publicly administered work will be the continued interest of the same men and women who were originally responsible for it before city control was assumed. To this end nursing bureaus or committees should be created.¹ If the criti-

¹ An Ordinance Creating a Bureau in the Health Department of the City of Los Angeles to be known as the Bureau of Municipal Nursing, providing for the appointment of a Commission, and fixing its powers and duties.

The Mayor and Council of the City of Los Angeles do ordain as follows:

Section 1. There is hereby created in the Health Department of

cism, so often meted out to municipal methods, can be replaced by sympathetic assistance, based on personal knowledge of working conditions, from the same class of citizens who are usually responsible for the work of visiting nurse associations, there would not be that wide gulf sometimes noticeable between the two branches of the same activity.

That many an intelligent and interested director of a well-managed visiting nurse association is totally uninformed of the progress of public health work as done by his own municipality is a recognised fact, and but indicates an attitude of mind too well known to require comment. If, however, we are to permit and even encourage a tendency toward an increased assumption of responsibility by state and municipality the fact must be recognised that individual responsibility ought to be thereby increased, not lessened, for what is the state and what is the city but an aggregate of individuals on each one of whom whether they wish it or not is bestowed the moral responsibility of citizenship.

The third problem, that of the advisability of specialisation in nursing, is one about which there is great difference

the City of Los Angeles a bureau to be designated as the Bureau of Municipal Nursing. Said bureau shall be conducted by a commission of five persons not more than three of whom shall be doctors or nurses. Said Commissioners shall be appointed by the Health Commissioner for such term as may be designated by him, but in no event to exceed four years from the date of appointment, and all members of such commission shall serve without compensation. Said Commission shall organise by electing one of its own members President and may elect such other officers as it may deem necessary. Said Commission shall hold regular meetings at least once in every two weeks and three members shall constitute a quorum.

Section 2. Said Commission shall, under the direction and supervision of the Health Commissioner take charge of school nursing, instructive visiting nursing, contagious nursing, emergency nursing, and nurses for investigation and inspection. Said Commission shall from time to time recommend to the Health Commissioner such action with reference to the proper methods to pursue in the carrying out of municipal nursing as in its judgment may be deemed necessary.

of opinion. Miss Ella Phillips Crandall describes the growth of this tendency so well that I quote her words: "The present highly specialised service of public health nurses is a logical, if not an inevitable, result of the gradual growth of public consciousness and conscience regarding better standards of living in general and of health in particular. The tuberculosis nurse came as part of the world wide campaign against tuberculosis, the school and infant welfare nurse in response to the demand for a fair start in life for infants and children, the medical social worker as an indispensable factor in the practice of preventive medicine, and the industrial nurse as a part of the employer's effort to keep his most valuable asset, the workers, in the best possible trim. As each need was recognised money was appropriated to meet it, and the donors prescribed interest, and the workers' obligation not to divert the funds from their specified purpose, naturally produced specialisation and the present questionable status of public health nursing service."

We hear much of the disadvantages of duplication of work due to specialisation. The story of the family whose five members were visited by five nurses because each patient required special advice or care is both picturesque and telling, but the detail of duplication is not the most important point in the question of specialisation. The main issue is whether the people, individually and as a whole, now and in the future, will be better served if public health nurses specialise, as do the doctors, in certain lines of work. Both specialisation, and what, for want of a better word, may be termed generalisation, have their weak points, and in considering the subject we would do well to separate the weaknesses that are inherent parts of the method, and those which are due to poor administration. Neither the absurd lengths to which specialisation has been carried, nor an unawakened interest in preventive work on the part of some few general nurses, should be

allowed to condemn either theory. With all due regard for dangers and limitations, each must be judged by its possibilities under the best possible administration.

Opinion among nurses is fairly evenly divided on the subject, some of the most thoughtful and experienced nurses believing that public health nursing will always be best carried on by means of specialised nurses, while others, and perhaps an equal number, believe that specialisation has been carried too far and that only through a return to the general nurse trained to care for all types of cases can the best results be obtained. All are agreed that in the large cities generalisation presents serious difficulties and all are equally agreed that specialisation is financially impossible in small towns or rural districts which must inevitably be served by a single nurse. A few of those believing in a return to generalisation are inclined to feel that specialisation will always be desirable for the largest cities, and also in starting new forms of work. They feel, however, that the very large cities are not typical, and that agencies which are a part of purely educational institutions endowed for research form also exceptions, which will always have a part in any complete program. Perhaps, the crux of the whole situation lies in the difference of opinion as to the possibility of properly preparing general nurses for all types of work. Advocates of both methods are eagerly watching the experiments which are being tried in various cities to generalise work which has previously been carried on under groups of special nurses. The results of such experiments cannot be justly estimated in any short period of time, and hasty conclusions must be avoided. Nevertheless, each development of these experimental efforts is instructive and enlightening. The establishment in half a dozen cities of so-called Health Centres through which it is hoped to co-ordinate all the health activities of a district, both medical and social, is another experiment likely to prove illuminating.

The health centres cannot yet be said to have passed an experimental stage for they have nowhere been established in sufficient numbers to meet the needs of any city, nor do they necessarily mean a generalisation of nursing work, though the tendency is undoubtedly away from specialisation. A series of well-administered health centres would seem ideal laboratories for the trying out of many health experiments, not least among them the best method of bringing public health nursing to both sick and well.

Many things affect the question of specialisation in its local aspects. Nursing traditions, civic and political conditions, the personnel of staff, the attitude of the doctors, the sources of financial support, etc., etc. Each situation must, therefore, be studied in the light of its own local conditions, but a brief consideration of the two points of view may be helpful. The following are the arguments generally advanced by those who believe that generalisation of public health nursing is desirable:

First. From an economic point of view, that an unnecessary amount of money is spent both for transportation and for time when more than one nurse covers the same territory, and that the duplication of overhead expenses induces a temptation to economy of supervision.

Second. That the entrance of several different nurses into a household tends to weaken the influence of each, as the slightest discrepancy in method or advice is noted and dwelt upon, until the work of all is lost through confusion of mind.

Third. That the constant presence in the small district of one nurse so familiarises her to the people that they learn to call upon her readily for advice in health as well as in sickness.

Fourth. That for the average nurse variety of work acts as a helpful stimulus, and that the monotonous round of similar duties performed day after day cannot fail to

react badly upon her, and in turn upon her work. This is particularly true of tuberculosis nursing.

Fifth. Because as each individual phase of disease is more and more coming to be recognised as a part of the whole public health problem, requiring treatment as such, specialisation should be avoided as tending to delay, or prevent, such general recognition.

Sixth. That the excellent work now being done by single nurses who work alone in small towns or rural communities proves that all branches of public health nursing can be successfully dealt with by one nurse.

To those who believe that the greatest progress is only to be made through specialisation the foregoing arguments are unconvincing, for it is felt that the same reasons which have led to specialisation in other kinds of work, lead, and ought to lead, to it in the field of public health nursing.

If it is true that the doctor who spends his time in studying one form of disease becomes more expert in that disease than the general practitioner, and makes a greater contribution to the accumulated knowledge of the subject by carrying such knowledge farther than would be the case if no specialists existed, why should the same not be true of the nurse who works shoulder to shoulder with him, giving her aid not merely in the intelligent care and instruction of the patient, but by adding her quota to the existing knowledge of the nursing side of the question. That sacrifice must be made for this great gain is admitted, but that it is of such a nature as to make advisable the retrograde step of a return to the "general practitioner" alone, in nursing, is denied.

The first argument concerning the unnecessary, and therefore unjustifiable, expense involved in carrying on special lines of nursing by means of separate groups of nurses, can only be met by a frank admission that such expenditure can be justified only by a corresponding gain

in efficiency. The waste of the duplication of overhead charges is not, however, necessarily a part of specialised work, for its most ardent supporter would urge the grouping together of the various branches under one central organisation, thus avoiding this difficulty.

There is also a divergence of opinion in regard to the important financial item of time, even among those opposed to specialisation. Miss Mary Beard, in an article entitled "Generalisation in Public Health Nursing,"¹ in which she earnestly pleads for generalisation on other grounds, says: "It would take more time and money to adjust this situation (the single nurse in a small district) because, with a small area to cover and a variety of duties to perform, the work cannot be done as quickly as when the same routine is pursued every day."

The second point, as to the advantage to the patients of a single nurse, the influence of whose advice is not weakened by that of other nurses, is open to question; for occasionally in the multitude of counsel there is wisdom, and one personality is sometimes able to succeed where another has failed, presupposing, of course, a co-operation which will prevent opposing advice.

To the third argument, that the presence of a single nurse in a district so familiarises her to the people that they readily call upon her at all times, we could but agree were the single nurse always ideal, and removed from the human necessities of vacations, and sick leave, or the still more disastrous possibility of marriage or removal. Since, however, the ideal nurse is hard to find, and even when found is by no means permanent, does not greater strength lie in the reliance by the patients and the people of the district on what is represented by the uniform, than in a faith which is pinned to a single personality?

The fourth point, regarding the monotony of work for the nurse who specialises, is of importance, but though the

¹ The *Public Health Nurse Quarterly*, October, 1913.

majority of nurses might prefer the small district with the greater variety of activity, others are glad to eliminate all but a single type of service. Where, too, the special branches are controlled by one organisation, a nurse may be placed in different positions, thus varying her work before any touch of monotony reacts unfavourably upon her.

The danger expressed in the fifth argument, namely, that specialisation tends to foster a microscopic examination of a single aspect of a family situation, thus obscuring the problem as a whole, presents perhaps the strongest objection to specialised work. It is a danger common to all forms of specialisation, and can be avoided only by a broad-minded grasp of public health nursing as a whole, and a spirit of co-operation which will work for all-round accomplishment. In it, however, lies a real menace, and one which should not be lightly passed over.

The sixth assertion, that the excellent work done by nurses working alone in small towns or rural communities proves the ability of one woman to deal with the various aspects of such work, may well be granted. But on what foundation does her work rest? Is not a part at least of her success due to the fact that special nurses, in perhaps far distant cities, have carried the technique of the special branches farther than she would ever have been able to do, and that it is on that advanced knowledge that she is acting?

One practical detail of daily work has not been touched upon:—the danger that lies in the temptation to the nurse who carries all types of cases to hurry on to the patient acutely ill and needing bedside care, away from the mother or tuberculous patient who is anxious merely to “talk it out,” a process that is so valuable to the patient and that requires so much time from the nurse.

Setting aside the questions of practical detail, the greatest drawbacks to specialisation would seem to lie in the danger that a broad grasp of health problems may be

missed by those doing the work, that those ministered to may suffer from the effect of an unnecessary invasion of their homes by a number of nurses whose combined instruction is less advantageous to them than that of a single individual, and that those supporting the work may be called upon for unnecessary funds, because of waste in the expenditure of money for overhead expense, transportation and nurses' time.

These are objections not to be lightly met by those who urge a wise specialisation. An open-minded readiness to admit a mistaken position, with an equal readiness to retrace steps taken on a wrong path, should mark those genuinely interested in the welfare of the public health nursing movement.

The writer, with all modesty, because she so highly respects the judgment of those who differ from her, feels that these serious objections to specialisation are not insuperable. She feels that to reach the highest possibilities in special lines of nursing there must be women giving their entire time to these lines, and by so doing becoming experts in them, able to lead others, able to contribute to the literature which is so greatly needed, able, in short, to do for the nursing profession what the specialist in medicine is so successfully doing for the medical profession.

CHAPTER V

PUBLIC HEALTH NURSING FROM THE NURSE'S POINT OF VIEW

ALL good private or institutional nurses do not make good public health nurses. A certain educational spirit and a degree of executive ability, not perhaps needed to the same extent in private nursing, are indispensable, while resourcefulness and initiative, less necessary in the ordered routine of a hospital ward, must be developed to a high degree if success is to be achieved in public health nursing.

As a woman stands on the threshold of her nursing career, with the decision before her as to which way she shall turn her steps, she would do well to take time for careful thought. It is sometimes a difficult matter to extricate the round peg from the square hole, and valuable time may be lost in the operation.

There are three things every nurse has a right to seek in making such a decision. First, that the work she chooses should be worth doing; second, that it should be done under conditions which will destroy neither her health nor happiness; third, that she should receive for it a suitable financial remuneration.

In addition, she is quite justified in considering the effect of such work upon herself and her own development.

Let us look at public health nursing in the light of these requirements.

The first requirement, that the work should be worth

doing, is certainly met by this latest branch of nursing. Indeed, this field of work could hardly be at a more interesting stage of its development, or one in which the best type of women is more needed. The experimental stage is over, and a sufficient number of years have passed since the simple beginnings by the first district nurses produced results which have proved the vital need of such work the world over. On the other hand, public health nursing has not yet reached its maturity, and, as in all new enterprises, the worker has the stimulus of the enthusiasm and rapid growth common to all young life.

No one need feel that in becoming a public health nurse she is joining an already sufficiently large army. Both recruits for the ranks and officers to command are still greatly needed.

At the time of writing (1916) visiting nurse associations with money in hand are waiting to secure properly trained nurses, while positions of large responsibility are left for months unfilled because of the difficulty of obtaining the right women.

Granted, then, that public health nursing is worth doing, and that there is room for new recruits among its ranks of workers, we may pass on to the second requirement, that in respect to the healthfulness of the life, and the relative happiness of the nurse in it.

Public health nursing has now become so large a term, embracing so many fields of activity, that it is difficult to generalise in regard to it.

In the greater number of its branches, however, home visiting is implied, which means outdoor life, and practically nowhere is night work required. These two things make of it for the average woman a healthful form of work. It is, nevertheless, hard work, and no account can be taken of heat or cold, wind or storm. For the nurse, therefore, with physical weak points, such as a delicate throat which succumbs to constant exposure, or a heart

which makes much walking and climbing of stairs undesirable, other work would probably be better. The word, "*probably*" is used advisedly, because many nurses, who in private or institutional nursing have been far from strong, have found that the regularity of their night's sleep, and the increased appetite produced by the outdoor life, have more than compensated for the hardships of exposure to weather or the difficulties of tenement nursing.

While arrangements differ in different places and with different types of work, as a rule, Sunday duty where a number of nurses are employed, is only taken in rotation by the general nurses, and for those engaged in special work Sunday is a free day. For the nurse working alone, it is made as easy as possible. One additional free afternoon is usually allowed, and it is almost universal for public health nurses to receive one month's vacation, with salary.

It is most difficult to strictly regulate the daily hours of work, because of its fluctuating character, but there is a growing feeling that not more than eight hours should be required, or indeed, allowed.

As regards the regularity of hours, it is in many instances a question of individual good management. Some nurses are able to cease their work with almost the same promptness with which it was begun in the morning, while the lunch hour is taken at the appointed time as a matter of course. Others constantly find it necessary to work over time, and make of the noon meal a movable feast to be partaken of anywhere between the hours of eleven in the morning and three in the afternoon. It goes without saying that for the latter type of nurse indigestion and fatigue are common, but these dangers are not inherent in public health nursing, as every superintendent of nurses will affirm, for the best managed district will usually be found to belong to the nurse who so plans her work as to

gain for herself, except in emergency, the inestimable advantage of regularity of hours for food and rest.

Whether the life of the public health nurse is a happy one, must be to every individual woman a personal question. Unless the work itself brings happiness she had far better turn to something else, for otherwise the sordidness and misery among which many hours of each day must be spent will prove hopelessly depressing.

The nurse who takes up such work merely because the hours are short, or the evenings free, and who lives through the hours of her working day in order that she may enjoy these advantages, even though she conscientiously means to do good work, rarely meets with enough success to insure a happy life. Unsuccessful public health nursing has its own peculiar disadvantage, for not only is there the discouragement of personal failure, but, because the work is so linked to other forms of work by the co-operative-ness of its character, weakness or failure means loss of strength to other social forces. Even if unconsciousness of this fact blunts its worst discomfort for the nurse unable to see the opportunities she is missing, others are not so blind, and short shrift is apt to be given the worker responsible for such a situation.

Fortunately it is not often, that the work is not enjoyed by the nurse who has chosen it. Affection and gratitude flow forth so freely from the patients, there is so much room for individuality of thought and method, there is so little of monotony and so much of variety, so many different types and kinds of people are encountered, and above all, tangible results are so plainly to be seen, that for the right nurse the life is full of absorbing interest. Nor do the hours of work form the whole of the nurse's life, for she has the opportunity to develop other sides of her nature. The shorter working hours, and the assured freedom of her evenings and Sundays, make possible the taking up of other interests and pursuits, and, as

a rule, public health nurses are found to avail themselves of these possibilities, often pursuing courses of study far removed from nursing, or turning their attention to music or painting on free afternoons or evenings. The broadening effect of these outside interests are quickly reflected in the nurses' character, and do much to prevent, or relieve, the wear and tear on the nervous system produced by a single mode of thought and occupation.

It may also be accounted an advantage that home life is made possible for nurses fortunate enough to find positions in their home town, though such a nurse and her family will do well to recognise, at the outset, that after her day in the district she will not be able to set about another form of mental or physical work the moment she enters the house. This is not expected of a man, and should not be expected of the working woman.

It is difficult to discuss the third requirement, that concerning suitable remuneration, because the whole question of salaries is in so unstable a condition as to make any statement regarding them of little value. It may be said, however, that as a more specialised training is required, the tendency has been to raise the salaries in all branches of the work.

At the time of writing (1916) salaries for staff nurses run from sixty to eighty-five or ninety dollars a month, with a few higher, a rising scale being adopted by many associations by which an increase is made automatically each year of the nurse's stay, the maximum being reached in most cases in the first two or three years. Superintendents' salaries run from twelve hundred to two thousand or twenty-five hundred dollars a year, and occasionally higher. Living expenses are not usually included, but as a rule uniforms are furnished. It is almost universal to allow one month of vacation on full salary, with the stipulation that no work for remuneration shall be done by the nurse during this period.

It will be felt that, compared with the salaries paid to private nurses, this does not make a very good showing, and in the short run it certainly does not. In the long run, however, the scales may not be found to tip quite so heavily to the side of private nursing. Even the most successful private nurse must lose a certain amount of time between cases, and her vacations and periods of illness cause a complete loss of income. If the nurse is not unusually strong this loss of time increases as she grows older, for the exigencies of private nursing are hard on health. The public health nurse, on the other hand, is apt to lose very little time. Her night's rest fits her for her day's work, her free afternoons and Sundays for her week's work, and her month of vacation for her year's work. As a rule, salaries are paid during short illnesses. Taken, therefore, over a period of ten or twelve years, there is less difference between the total receipts of the public health nurse and those of the private nurse than might have been expected, and if there is a difference in that most important financial asset, physical health, it is likely to be to the advantage of the public health nurse. Moreover, experience in most instances increases her earning capacity, and this, for some inscrutable reason, is not usually the case with the private nurse.

Compared financially with institutional positions, public health work is undoubtedly at a disadvantage. The institutional nurse receives not only a relatively higher salary, but is assured of hospital care in case of illness. This is not infrequently arranged for the public health nurse, but it cannot be counted upon.

On the whole, for the average good nurse capable of successful work anywhere, the public health field is perhaps the least well paid of the three branches of nursing. On the other hand, a steady and assured income may be relied upon, and positions are plentiful. To the exceptional nurse with executive and administrative ability good

salaries are offered, and for all, the tendency is toward greater remuneration, as the standard of efficiency is raised.

The query as to the effect of public health nursing on the character and development of the nurse herself, can be spoken of with some assurance.

It is a truism that one gets out of anything only what is put in, and some of the finest and broadest characters have been developed under most adverse circumstances. This is daily demonstrated by women who voluntarily spend the best years of their life closely confined with chronic invalids, who do not even furnish the stimulus of physical improvement. On the other hand, the most favourable conditions fail to jog other women out of their narrowness and self-absorption. It may be said of public health nursing, that it is difficult for a nurse engaged in it to retain these undesirable characteristics, and that it is easy for her to gain a breadth of view and a human sympathy which will do much in the moulding of her own character.

Because the public health nurse works with so many others, representing entirely different points of view, she learns that, important as her own efforts on behalf of her patients may be, all is not done for any man or woman when mere physical health is secured. This broadens her outlook on the whole of life.

Seeing her patients in the midst of their own natural environment, she learns of their temptations, struggles and limitations. This teaches her sympathy and understanding. Because she is dealing with human nature uncontrolled by the abnormal and temporary restraints of hospital life, she learns she cannot always make people do what she wishes. Her many failures to accomplish her own purpose teach her greater tolerance for the failures of others.

Because she carries individual patients or families for

long periods of time, or constantly returns to them, they learn to love and depend upon her. This develops that mother spirit of tenderness and longing to help without which this type of work is rarely successful.

And lastly, because her life is spent in dealing with such a variety of people, patients, their families, doctors, municipal authorities, and co-workers, she learns that most valuable lesson, a knowledge of human nature, and her wits become sharpened by constant exercise.

These opportunities for development of character do not, of course, lie in the field of public health nursing alone, but they are to be found there, and are open to the nurse who will seize and make use of them.

Owing to changing conditions and the varying situations existing in different localities, it would be futile to suggest a fixed line of procedure for a nurse who is intending to do public health work. It is safe, however, to urge that no one without either special training or experience should undertake it alone. If a nurse has had no opportunity of seeing anything of public health work she will doubtless feel quite capable of giving the bedside care which her hospital training has fitted her to give, and which will probably represent to her all that there is in public health nursing. Should she, at the request of a board of managers as ignorant of the subject as herself, undertake to start and carry on such work with this limited point of view, she will at best gain her experience at the cost of many unnecessary mistakes and considerable loss of time, and there is danger that she may never awake to the possibilities that lie on every side of her.

If special public health training is out of the question, a few weeks spent with a good visiting nurse association will, at least open eyes that might otherwise be holden, and will prove a starting point for further effort along the right road.

Wherever possible, definite post-graduate training is strongly advised, and time and money spent in obtaining it are sure to be well invested by the nurse who desires to become truly successful in this branch of nursing.

PART II

VISITING NURSING

CHAPTER I

HOW TO ORGANISE A VISITING NURSE ASSOCIATION

THE public health nurse has been defined as a graduate nurse who is doing any form of social work in which the health of the public is concerned and in which her training as a nurse comes into play or is recognised as a valuable part of her equipment.¹ In the past all such nurses were called district or visiting nurses. More recently these terms have been applied in a somewhat narrower sense to nurses who work within prescribed districts giving bedside care to their patients, while public health nursing covers not only the work carried on by the district and visiting nurses, but also that of the medical social service nurses, the milk station nurses, the school nurses and those engaged in all of the various special branches of the work.

The district or visiting nurse works as a rule under an organisation known as a district or visiting nurse association, the names being synonymous. Such associations not infrequently undertake in addition to district nursing one or more of the special branches of public health nursing work. Undoubtedly these associations will in time be known as public health nursing associations, the name being more truly descriptive of the work done by them, but as yet, those best known in the country retain the old names under which they came into existence.

There is a growing tendency for states and municipali-

¹ Anna M. Brainard, "The Administration Side of Visiting Nursing."

ties to undertake public health nursing work in all its forms. As this tendency is by no means universal, and as there are many communities in which public health nursing is wholly dependent upon private initiative, a consideration of the question of the inauguration of such work as a private enterprise may be found helpful.

So great has been the emphasis laid upon the public health nurse, that the importance of the organisation behind her is often overlooked. On it, however, depends all permanent success, for no nurse, were she Florence Nightingale herself, could achieve lasting results unless the foundation on which she stands, the organisation, is good.

Though there are few communities which do not need a visiting nurse, the demand rarely comes from those who themselves require her services. If it be a city or town, the impetus usually comes from those within the community itself, who, though they may not expect to profit from the new venture, yet see for themselves its advisability. If it be a village or rural district, the impetus sometimes comes from a chance summer visitor, or from those who for one reason or another feel some personal interest or responsibility in the welfare of the people.

The former situation is a simple one. Those interested are on the spot. They know or can easily ascertain the facts as to actual conditions, and a feeling of responsibility may be expected from them. When, however, all interest in the project comes from without, a more artificial and less natural situation exists. Here there is danger that the work will not be started on a permanent basis, that the financial responsibility will rest with a single individual, or at best with a small group of people whose interest, because of absence or the weight of nearer responsibility, may wane, or that ignorance of local conditions will produce unsatisfactory results.

These dangers may, perhaps, best be avoided by an

earnest effort to gain the co-operation of the more intelligent people of the locality itself, for, above all, permanency is desirable. The withdrawal of a nurse after the patients have learned to count on her skilled services is a form of cruelty not always realised by those not in direct touch with the sick.

In starting public health work in a new locality, the scope of the proposed enterprise should first receive consideration. It occasionally happens that circumstances have brought to the attention of those interested some one of the many branches of public health nursing, such as tuberculosis, or infant welfare work, and, filled with enthusiasm for the good that is being done elsewhere by means of these special nurses, they endeavour to start merely this special work in the new field. This is a mistake, for the safest and surest foundation on which any public health work may be built is the general nursing care of all the sick of the community, irrespective of class, age, or type of disease. When this has been provided for, special branches of nursing may be added, but unless the already sick are being adequately cared for, it is almost an anomaly for public health nursing to exist, because a nurse, who must leave a patient in dire need of nursing care when there is no one else to bestow it, is likely to preach her gospel of prevention to deaf ears.

As regards the amount of territory to be covered by a nurse, that of course, must be a question of local geography and local means of transportation. Generally speaking, it is well to undertake only what can be well done by one nurse, though occasionally it may be found advantageous to start two nurses at the same time in order to gain the financial support of a larger geographical area than one nurse could attempt even at the beginning.

Whether those interested belong to the place itself, or whether they have gained their interest in some other way, the first step should be an effort to become familiar with

public health nursing as done in other places, for it is a waste of energy to make avoidable mistakes.

In small towns, public interest can perhaps best be aroused by an open meeting held in the town hall or some public school building. Usually a church, no matter how convenient, should be avoided, lest there be an appearance of sectarianism. Preliminary meetings will naturally have been necessary, as at this open meeting a very definite proposition should be placed before the townspeople, and the leaders should have taken pains to secure beforehand the moral support of the various interests and creeds of the town.

At this meeting free discussion should be encouraged, and all objections and questions courteously met. A good visiting nurse should, if possible, be present, who will in a short address make the work vivid to her hearers, and who will be able to tell of the actual results obtained elsewhere. If a nurse cannot be secured, this must be done by some one else, for no abstract theory is going to make a sufficient appeal. While the necessity for such work among the very poor may be dwelt upon to some extent, the desirability of the nurse's services for all those of moderate means should receive due emphasis. Though the nurse will give free care to those who need it, the stigma of "charity nurse" must never be allowed to attach itself to her name.

Local statistics as to the infant death rate, or the number of deaths from tuberculosis, are apt to be telling, as are also local illustrations of the need of a visiting nurse if these can be used with safety.

Sometimes, it has been considered wise, after the vote for the formation of an association and the election of officers, to take pledges for support, or make immediate enrolment of members in order to strike while the iron is hot.

These simple methods of publicity, while sufficient in small towns, are naturally inadequate for the launching of

public health work in a city of any size. The central idea, however, is exactly the same, the bringing before as large a public as possible the aims and needs of the work. Usually in a city this is best accomplished by means of a carefully arranged campaign of publicity, in which the newspapers, the pulpits, local clubs, and personal correspondence may all do their part. Even when the need of a large staff of nurses is obvious, it is wise to start with a single nurse working in a circumscribed area. New districts may be opened as rapidly as is consistent with the building of firm foundations, and the more complicated methods of administration gradually adopted as needed. Meanwhile, mistakes inevitable to a new work will have been made under the shelter of comparative obscurity, and on a small, rather than on a large, scale. In other words, the natural and safe law of growth from a small beginning will have been followed. As the value of the nurse's work makes itself gradually and quietly felt in the part of the city where she works, the need of a like service will be felt by neighbours and friends living outside of the district. Doctors will have a practical demonstration of a nurse's value, which will make them wish to extend her usefulness to all their patients. Thus a healthful demand will be created which will greatly simplify the development of the work.

Nowadays it is not often that in starting a visiting nurse association in a large city, virgin soil will be encountered. Usually one or more visiting or public health nurses will be found in the field, caring for the sick in the vicinity of the churches or settlements which support them, or doing special work under the auspices of a tuberculosis league, child welfare society, or some other form of specialised activity. Not infrequently, where numbers of such independent nurses have been working for years, investigation has revealed the fact that whole areas of the city, and large classes of patients, are wholly unprovided

for, while, on the other hand, the duplication of work has brought the entire system of special nurses into disrepute.

The starting of an association in such a city is a difficult and delicate task, but, if accomplished successfully, it is well worth any effort. The ideal method of amalgamation under such conditions is the agreement on the part of those already employing nurses to place them on the staff of the new visiting nurse association, there to work in whatever field may be designated by the supporting agency, but under the supervision of the superintendent of the association and with a common uniform and conformity to a common general plan of work. If this can be accomplished, large concessions may well be made to the special wishes of the affiliating bodies as to methods of administration, local headquarters, etc., and ample representation should be given them on the board of managers and on all important committees. The selection of nurses must eventually rest in the hands of the superintendent, but if she is a wise woman she will do her best with all old nurses, and will realise that much time will be required, and many experimental efforts made, before a thoroughly satisfactory working basis can be evolved.

Failing in such an arrangement as this, and it is rare that agencies already employing nurses are ready to agree to so far relinquish their own supervision to a new and untried association, a central committee may be formed, in whose hands may be left general policies, and which, by careful districting of the city, may do much to prevent wasteful duplication of effort.

In all arrangements, greater strength will be found to lie in greater centralisation, but coercion is of little use, and it is wise to accept co-operation on whatever terms it may be offered, hoping always that growing confidence may increase the willingness to unite.

The very desire to hold tightly the reins of power

shows an interest the value of which must not be underrated.

Even if no affiliation at all can at first be accomplished, there is no cause for discouragement. Let the new association place upon its board representatives of the bodies already employing nurses, and then, by good work and a broad grasp of health problems, let them slowly earn public confidence. When confidence is theirs, they will be in a better position to seek amalgamation, and they will not speak to uninformed ears, if the inner workings of the association are already familiar to the outsiders through their representatives on the board.

After the formation of a visiting nurse association, whether it be in a city or town, one of the first questions to consider is that of membership. This may be conferred on those who give financial support, or, as is customary with some hospitals, there may be a large enrolment in the corporation of members voted in by the board because their backing and moral support is desired, and who may, or may not, contribute financially to the association. In smaller places the former method works well, and in some instances, membership may also be conferred on persons unable to contribute in money, but whose contribution of time or interest is equivalent to, or far exceeds in value, the usual annual dues. All members have a vote at the annual meeting, but are not usually convened except on that occasion.

There are two ways of administering the affairs of an association; through a small board of managers meeting frequently and regularly, or by means of various committees of a larger board. Both methods have their advantages, but greater responsibility is thrown on each member of the smaller board, and as a rule responsibility develops the individual.

A number of well-managed associations have a board of from ten to twenty members. These boards meet

monthly, transacting all business, guiding all policy, and holding themselves responsible for the financial status of the association. Many in small towns have but one standing committee, that on supervision of nurses. This committee, usually composed entirely of women, meets once a month, sometimes oftener, going over with the nurse or superintendent of nurses each detail of the work, and out of the fulness of this intimate knowledge making recommendations to the board.

It is a question whether there is greater strength, or greater weakness, in relieving the board as a whole of the details of financial responsibility, by the appointment of a small standing finance committee. A board, thus relieved, is too apt to leave the entire matter of funds in the hands of such a committee, comfortably voting away money which it has made no effort to raise, and which the harassed finance committee finds itself unable to secure unaided. On the other hand, without such a committee it is sometimes found that the responsibility of getting money is too diffuse if left to the entire board, and is really assumed by no one.

In large cities, a number of committees will eventually be found necessary, but in their early appointment great care should be exercised to avoid such a division of responsibility as will make the work as a whole difficult for the board of managers to grasp. In the early days it will prove more educative if the board itself finds it necessary to grapple with the various problems which later may be almost entirely turned over to standing committees. Even, however, where such committees exist in their most efficient form, carefully prepared reports should be made at each monthly meeting of the board, if continuity of purpose is valued.

We have spoken of the necessity, even in the smallest association, of a standing committee on nurses, to concern itself with the detail of the work to be done; and also of

the possible desirability of a like committee on finances, which will bear the responsibility of providing the means to accomplish it. A third committee naturally suggests itself, that on supplies, loan closets, headquarters, etc. It is poor economy to allow any of the nurses' highly paid time to be spent on these housekeeping details. A third standing committee, therefore, for this part of the work is usually to be desired, though it is sometimes well done as part of the work of the committee on nurses. Whatever the standing committees may be, temporary committees can of course also be appointed, such as nominating committees, committees to arrange for the annual meetings, and for the printing of the annual reports, as well as special committees to deal with unusual conditions, either of a financial or administrative nature.

If a town has no relief-giving agency to which the nurse may turn for assistance for her patients, a committee on relief is necessary which may apply itself to the study of approved methods of dealing with that most difficult of all problems. It has been found, however, that it is far better that such a committee should not exist as a part of the association itself, because as has been explained in a previous chapter, the nurse's position is stronger if the patients do not look to her in any way for material assistance.

Members of committees need not necessarily be members of the board of managers, though it is well that the chairmen should be so, in order that all the work of the Association should be guided by one general policy, thoroughly understood by those dealing with the various details.

It has sometimes been felt that the administration of a visiting nurse association should rest in the hands of women, because nursing is essentially a woman's work. This might have been true in the earlier days of the movement, when nursing of the sick alone constituted the duty

of the nurse. Now, when the work is so much more complex, and when co-operation has been so highly developed, even in the smaller places, as to involve the association in an incalculable number of issues undreamed of before, we can ill afford to do without the judgment and experience of both men and women. The point of view is inevitably different and both angles are valuable.

As regards finances, it is impossible to make suggestions which will be appropriate to the varying local situations. One general rule, however, may be laid down. The greater the education of the people to the real need of the nurse, the greater the financial strength.

Perhaps the simplest and most direct means of getting money is through the annual dues of a large membership. This support may in the main be counted upon, because individuals have usually become members through belief in the work done by the association.

With the use of such means as fairs, bazaars, charity suppers and dances, tag days, whist parties, plays, etc., other reasons for giving enter in, and the whole amount of the sum so donated does not find its way into the treasury, as expenses are usually deducted. Also, these means of getting money are considered, by those who have studied the question, undesirable from various points of view. People making small purchases at fairs and bazaars are apt to consider that they have given sufficient support to the work, and will feel no further responsibility; while the dances and card parties have in their very nature undesirable elements, unless most carefully managed. Tag days, though a more direct means of giving, require the expenditure of much time and thought if they are to be really educational and not irritating in their effect on the community, and only those genuinely and intelligently interested in the work should be allowed to solicit.

The question of a town or city subsidy is a mooted one. In some places it has certainly worked well, no string be-

ing attached to the gift. In others, it has been found that the freedom of the association in attacking abuses has been interfered with by the fact that its own existence depended in a measure on the pleasure of the town council.

Sometimes, if the occupation of the locality be manufacturing and no industrial nurses are maintained, substantial support may be furnished by the mills, the proportion each one gives being in accordance with the number of hands employed.

Again, small clubs, churches or stores may make themselves annually responsible for a certain sum. This arrangement may be made interesting to them by the publication in the local newspapers of their responsibility for the support of a nurse, for perhaps a day or a week, or a month.

Nothing, however, should be allowed to interfere with the principle that those who can do so should pay for the nurses' services according to their means, the highest amount charged usually being the cost price of the visit, all overhead charges being taken into account.

The only exception to this rule should be cases for whom indirect payment is made through insurance companies, fraternal orders, or benevolent associations, or of those whose care is paid for by their employers or others. The amount of money collected from patients, or those financially responsible for their care, will differ greatly in different localities, but there are few places where it will not be necessary to give a goodly percentage of free care, or care far below the cost price. So slender a margin exists between independence and dependence with the majority of district patients, that even a short illness usually wipes it out altogether, and as yet no satisfactory method of organising public health nursing on a paying basis has been devised in America.

When all probable sources of income have been considered, there is, alas, apt to be a deficit between the estimated

income and the estimated expenditure, and it is the meeting of this situation that constitutes one of the principal responsibilities of the board of managers.

No association need be afraid to start the work if it has the money in hand to meet the running expenses of the first six months, provided the nurse engaged, who may be leaving an assured position, understands the exact financial status. As a rule, the reports of results already accomplished, and the fact that a nurse is actually at work, tend to bring in funds as no roseate promises of the future succeed in doing, and it is rare that a nurse once started is given up for financial reasons. The nurse's own freedom from the weight of financial responsibility should be very carefully guarded. She cannot do justice to her work if, in addition to it, any such burden is laid upon her. She may rightly be expected to present the work publicly when asked to do so, and can always at the same time make a statement of the financial situation. Such talks, however, are, in the long run, more effective if made with the view of educating the audience to an understanding of public health nursing, than when the note of appeal is too vigorously struck.

So far we have dealt only with work which has been started in what may be called the legitimate way, namely, with a visiting nurse association as the administrative power.¹ This, it is believed, should be the ultimate form of administration, unless unusual conditions exist, for public health work is too highly specialised to allow of development to the fullest extent possible if it is carried on as a branch of some other activity. Occasionally, however, the fear of too hastily forming another organisation in a community, perhaps overstocked with associations and societies, will make the starting of the nurse by some already existing agency seem wise.

¹ In the present chapter we are not considering work organised under state, county or municipal control.

Also in small places, where leaders are few, it sometimes seems absurd to start a new enterprise with exactly the same people who already hold similar positions in a club or society which might possibly take up the work; as for instance, a civic club, congress of mothers, or other society with a broad programme of activity.

In every instance, one thing should be borne in mind, that a special committee should be appointed whose sole responsibility will be the nursing work, and who will expect to give both time and study to the question of its development. This committee will be the best judge as to whether the work is strengthened or weakened by its connection with the parent body, and when the time is ripe, will be able to effect a separation without loss of continuity of method.

A town poor department should not inaugurate public health nursing, as in its very nature it would then be limited to the poor. And for this reason it is not considered best to place the work under the auspices of a charity organisation, in spite of the very obvious convenience of such an arrangement. Though the more enlightened realise that the societies for organised charity do as much preventive as alleviative work, still to the great body of the people they stand as relief-giving agencies, and those able to pay for nursing care hesitate to employ nurses connected with them.

The question of the use of pupil nurses sent out to do public health work during their period of hospital training, will be dealt with in a later chapter. It is sufficient here to merely say that, unless proper supervision can be afforded the pupils, a hospital had best not undertake to do visiting nursing through its pupil nurses, in fairness to the nurses, to the patients and to the work as a whole.

There is one situation that is always a little difficult to deal with. A single individual will sometimes wish to start public health nursing by giving the salary of a nurse

on condition that there is to be no "red tape of organisation." This is to be deprecated, except as a very temporary experiment. General public interest is not aroused, permanency and development are not assured, and the check of more than one opinion is not placed upon methods of work.

Also there is danger that the "lady bountiful" atmosphere may pervade the whole, an atmosphere which seriously interferes with healthy growth.

If any individual wishes to place a nurse in the field, two suggestions may be made. First, that only a portion of the salary be paid by that individual, the first half at least being raised by the usual means; and second, that associated with the individual effort, should be that saving grace, a committee, each member of which shares equally, except financially, in the responsibility of the undertaking. Should then the work increase so that more than one nurse is needed, the question of additional funds could be met by this committee, and the work thus avoid the danger of being limited by the ability of one person to support it. In this, as in all other methods of starting work, future opportunity and development should be borne constantly in mind.

The selection of the nurse is usually in the hands of the committee on supervision of nurses, and too much cannot be said of the great importance of starting with the right woman.

No matter how perfect the organisation, or how splendid the board of managers, the nurse is, and must always be, the actual point of contact. Successful development will depend on her ability not only to do the work, but to see it and so present it, as to both arouse and keep the intelligent interest of the board, and through this of the whole community. No novice in public health work can do this. Large well-organised associations can, perhaps, afford to place nurses without public health experience in

subordinate positions, to work under thoroughly trained public health nurses, but the small town or rural district must have a nurse who has had such experience at least, if not special training, and inquiry of the most searching kind should be made as to her powers and abilities, not merely as a woman, and a nurse, but as a woman and a nurse and a public health nurse.

It is to be hoped that in thus considering in detail the many points connected with starting a visiting nurse association, no note of discouragement has been sounded. There is, perhaps, no other work which meets with so ready a response to a call for help, throughout the length and breadth of the country, or any in which grateful appreciation can be so counted on to keep up the spirits of the workers. A good board of managers of a visiting nurse association, and a good nurse have been known to form so strong a unit as in a few years to radically change conditions in a community by no means noted for its progressiveness.

Three things may be urged upon those who think of starting public health nursing. First, realisation that really important work lies before them which they can in no wise do vicariously through their nurse, but to which they must expect to give of their best, for no nurse can work successfully unsupported. Second, that the work must be entered upon with minds hospitably inclined to new ideas, new methods, new developments. So young a movement must not be crippled by being limited in its growth by any rigidity of preconceived ideas. Third, the fact must not be lost sight of that this is not an isolated group of people working alone for better health in one locality, but is an important link in the great chain of the public health movement, and that the strength of the whole is their strength.

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CHAPTER II

THE BOARD OF MANAGERS

PUBLIC health nursing work naturally divides itself into two parts, served by two different groups of people.

The first group has for its responsibility the guidance of policy, the making of laws, the raising of funds, and the selection of nurses, the manufacture and care, in short, of the machinery which makes possible the working of the second group whose responsibility lies in the actual performance of the work for which the organisation exists.

Leaving entirely aside for the present the second group, the nurses, let us consider the duties and responsibilities of the first, the officers and managers of an association existing for the purpose of public health nursing in any of its forms.

The responsibilities of such a board are two-fold. It is responsible to the community for the work which it has undertaken to do, the care of the sick and the education of the public in health matters, and it is responsible to those whom it employs to do this work, for their welfare and happiness. The gathering of money, the attendance at meetings, the serving on committees, the reading on public health subjects, the time spent in gaining an intimate knowledge of detail, all these things are but means to the end of fulfilling these obligations.

Any corporate body quickly attains a certain personality and individuality of its own, the result of the blending of the various characteristics of its members. This

is a point not always recognised by the men and women composing such a body, who forget how potent for good or evil, strength or weakness, their own characters may be. United strength can move mountains, or perform the even more difficult task of creating a healthful community, but unity without strength, or strength without unity, are powerless to produce results.

There are three types of managers, all valuable to a good board. There is the man or woman genuinely interested in the work, or ready to become so, who is willing to attend meetings regularly, who serves on committees, and gives time to necessary detail work, the manager, in other words, who carries the burden of the association on his shoulders. There is, also, the man or woman whose expert knowledge in some particular line is of great value, but who, though ready to be made use of on occasion, is unable regularly to attend meetings or to give time to ordinary committee work.

There is also a third type, whose value is potential rather than actual. The young man or young girl whose youth and inexperience make their present contribution to the association small, but who later will work into the positions formerly held by their elders. Every board should have a few such young members, for without them, fine as may be the present status of any association, no provision is being made for the future, and the kind of dependable interest most to be desired cannot be built up in a moment, but is of slow acquisition.

In the first selection of a board of managers, or the filling of vacancies, a certain balance ought, if possible, to be maintained. Beside the three individual types of members just mentioned, an effort should be made to secure representatives of the three religious groups, Protestant, Roman Catholic and Jewish, as also of any well defined interest or section of the community. Neither men nor women should be allowed to predominate, nor should

the members be selected from one small geographical area, or one, small or large, social set. The prestige attached to so-called social position, cannot, and should not, be ignored, but public health work ought not to be carried on by any small clique in social life or confined to any social set, no matter how desirable each particular member may seem. On the whole, it is wise to make some sacrifice of individual worth in order to secure a board which will be representative in the broadest sense of that somewhat abused word.

As regards individual personality, neither the extremely radical nor the extremely conservative need be feared, for both these points of view will help the board to find that *via media* along which lie the best results. The same may be said of members who have bumps of criticism so well developed as to make them somewhat trying as co-workers. Such criticism is usually far more valuable if applied from within by a member of the board, than when applied from without, hence it is sometimes wise to gather into the fold such an one, unless, indeed, dissension must be counted upon as a result.

There is one great temptation of which the nominating committee and the president should alike beware — the kind-heartedness which is unwilling to remove an unsuitable person from a position of responsibility, though his inefficiency acts as a drag upon the progress of the whole work. It is one of the most painful of duties to depose such a person, particularly when he is giving of his best, and is happy in the giving, but no important work should be allowed to continue to suffer on that account. The rare gift of leadership is not bestowed on every one, and many an unsuccessful chairman would make an excellent member of his own committee.

It goes without saying that this power of leadership should be possessed by the president of the association. In it is implied that knowledge of people which will en-

able him to make wise appointments, and with it should be combined the open mind which will hold wide the door to all new ideas. The routine of business will be much simplified if he is a good presiding officer, and if in addition he can be a man of professional, business or social prominence, so much the better, though often too high a price is paid for these latter advantages, and some one is selected who has no strong personal conviction of the necessity of the work and on whom the responsibilities of the office sit but lightly. If we have persistently alluded to the president in the masculine gender, it is rather because of the lack of a personal pronoun in the English language which can be used for men and women alike, than because of a belief that a man alone should hold the office. There are various advantages in a man president, but ability and interest, not sex, should be the standard for eligibility.

It is usual, but it is rather dangerous, to make the vice-presidencies purely honourary positions. Not a few associations have been obliged to limp painfully through a year because sufficient provision has not been made for the unexpected incapacity of an able president.

The smooth running of any board of managers is more dependent than is always understood upon the ability of the secretary. The work of the president is greatly facilitated if he finds in the secretary a strong right hand on whom he can depend for all the details of the work. Usually a woman is desirable because of the amount of time she is willing and able to give, but she must be a woman of tact and business ability, for through her the association will be presented to the outside world.

The treasurer should unquestionably be a man, because the dealing with money is more usually done well by men than by women, and because a good business man's name is apt to carry weight with possible large contributors.

Perhaps the most important office next to that of presi-

dent is the chairmanship of the committee on supervision of nurses, or whatever that indispensable committee may be called. This should be held by a woman, and one who is willing to give a great deal of time and thought to the work. Above all, she must possess sympathy, initiative, and a practical mind, for the nurses must be able to lean upon her in their difficulties, sure of a genuine and helpful understanding. Wisdom, too, is a requisite, for on the reports and recommendations of her committee will largely depend the legislative action of the board.

As regards other committees, the wise president will study the personnel of his board, and in making appointments will take into consideration the educative value of committee work, as well as the ability of the members. Though the chairmanship should always be given into capable hands, there may be placed to advantage on each committee some of the young or inexperienced members of the board, whose interest will in this way be aroused and stimulated, while they unconsciously learn many lessons which will later prove of value to the work. Too often there is no one to take the place of the few tried veterans, who, owing to their ability, have been allowed to carry all the responsibility and to do all the work, and whose death or removal, leave the association almost hopelessly crippled.

In the ideal board of managers, each member contributes according to what he has to give, the president knowing where to lay his hand upon the kind of service needed at any moment. One thing constantly proves itself. The inactive board is the uninterested board. Few members ever resign because of overwork, but many drift away because they feel that they are not needed.

We have spoken so far of the make-up of a board of managers, rather than of their duties. In order to guide any activity well two things are necessary, an intimate knowledge of the special activity to be guided; and,

equally important, a broad knowledge of how other activities of a like nature are guided elsewhere. The former knowledge is to be obtained by a regular attendance at meetings and an insistence that details be so presented as to make such knowledge obtainable, the latter, by reading on the general subject, and by correspondence with other associations.

If the members of a board of managers realised how stimulating intelligent questions are to the nurse striving, often perhaps ineffectually, to put her subject before them, they would less often, with pleasantly receptive faces, receive her report without comment. The presentation of her work has not been part of a nurse's training, and it must be admitted that she sometimes fails to make it interesting or even informing. She will never improve, however, unless her failure is pointed out by questions which will show her the kind of information the board desires. If this is a particularly weak point the chairman of the committee on supervision of nurses may be of great assistance, not only by helping the nurse to arrange her notes to better advantage, but by herself asking at the meetings such questions as will elicit the desired information in the most interesting form.

It is not always the nurse, however, who fails to keep the board informed. How often in reply to the request of the president for the report of some special committee, we are told that the chairman has nothing to report that day. Why has he not? If the committee has legitimately been inactive, let the chairman give the reason. Often the reasons for not acting are just as interesting as the reasons for acting, and the board should be kept informed of them. If any committee meeting has been held, the gist of the proceedings should be reported.

Public health nursing is in itself interesting, and if the monthly meetings are not made so, something is wrong with the way in which they are conducted. When the

nursing staff is large, it will usually be represented at meetings by the superintendent, but it is a pleasant custom that other nurses should at times be present, either singly or in groups, to present their own special phases of the work. Beside the different point of view to be gained in this way, it is an advantage that the various nurses, as well as their problems, should become personally familiar to those who guide their work. These things may seem minor details, but large issues are made up of details, and unintelligent legislative work is more often due to ignorance and carelessness, than to lack of ability to make wise decisions.

This brings us to the second part of the responsibility of a board of managers, that toward the nurse or staff of nurses.

Plain common sense impels the owner of any fine piece of machinery to keep it in good order even at considerable expense. A visiting nurse association employs but one type of machinery, its nurses. Why is it that they are so often allowed to degenerate physically by the very men and women who would consider such neglect the acme of bad management in their own business or household affairs? Any association which has to its discredit a record of unnecessarily impaired health for its workers, is being poorly administered, no matter what it may have accomplished in the way of health for the community at large.

Three things make for the health of the public health nurse: a suitable salary which will enable her to live comfortably, a strict limitation of her hours of work, except in emergency, and, as far as possible, the provision that her work shall be done under happy conditions.

The standard of salaries is at present in too fluctuating and transitory a state to be dealt with helpfully in this book. Suffice it to say that a board should keep itself informed as to the salaries paid elsewhere, and be

unwilling to place itself on record as paying less than the most enlightened.

If suitable salaries can not be "afforded," then the work is being done under false pretences, and the financial burden is in reality being placed on the shoulders of the workers, rather than where it belongs, on those of the community. The fact that many fine nurses are to be found, who for love of the work are ready and willing to labour for less than they are capable of earning, is no justification for underpayment, and such sacrifice should not be permitted. In nursing, as in everything else, it is poor economy to buy what is merely cheap. Some nurses are not worth the lowest salaries paid them, but they are not the nurses it is worth while to employ.

The restriction of working hours is not an easy matter, but no woman stands continued overwork well, though with some the inevitable day of reckoning may be delayed by a strong constitution. It is not enough that the nurse should be told that she must not work over eight hours a day. If it is the policy of the association never to refuse calls she simply cannot help overworking, unless it is likewise the policy of the association to add to the staff of nurses, either temporarily or permanently, as the need arises.

If this latter policy is not pursued, then the former should be abandoned, and the board should honestly meet the difficulty and map out for the nurse some logical method of limitation, which it will be within her power to pursue.

The question of meeting the constantly increasing demands of an inevitably developing work is a most difficult one, and is generally evaded by an expression of the vague hope that the nurse will somehow do her best. But it is not a problem for the nurse. It is a problem for the board and should not be shirked by them.

The best results in administration seem to be gained

by the exercise of great care in the selection of the nurse or superintendent of nurses, and by then leaving her a very free hand as to methods of work. If results are not satisfactory it is far better to make a change than to try by restrictive measures to guide details.

The best women will never be retained unless they are allowed free scope for the development of their own, not other people's powers, and it must be remembered that it is as impossible to gain results by arranging a groove, no matter how mathematically correct, down which the nurse must walk, as it would be to insist that she should wear for such exercise a certain size of shoe, selected because of its beauty or utility but without reference to the size of the wearer's foot.

Though the nurse or superintendent must work out her own salvation as to methods and administration, it is not meant that she should do so alone or unaided for she will need every particle of backing that the strongest board can give.

For those who have had an opportunity to study the inner workings of various visiting nurse associations, it is interesting to attempt an analysis of the causes of failure or success. Invariably it is found that these causes exist within the association itself, no outside influences or obstacles ever seeming capable of blocking progress if managers and nurses have the right point of view. On the other hand, the most favourable outside environment does not seem to have any effect in producing good results if managers and nurses are in themselves weak, or fail to pull together.

It falls to the lot of most superintendents of nurses to do more or less visiting among sister associations, either in the capacity of "speaker" at annual meetings, or as diagnostician of special situations. The experiences of one such superintendent in three different towns may serve as helpful illustrations of certain causes of failure.

In all of them the highest motives actuated the managers, and in all three a change of policy turned failure, or partial failure, into success within a comparatively short time.

The first experience was with an association apparently being carried along by the enthusiasm and effort of a single individual, the president, who complained somewhat bitterly of the utter lack of interest of her board of managers, and of their unwillingness to bestir themselves to help her in the difficult task of raising money.

The superintendent was asked to speak at the annual meeting, and went, with some curiosity as to the cause of this lack of co-operation.

The meeting was well attended, and there apparently seemed no lack of sympathy and intelligence among the audience, but the worried president again spoke of her difficulty in interesting her board in the work, some of them even going so far as to advocate giving it all up, on the ground that the effort to continue an association was hardly worth while. As the statistics of the year read by the secretary showed a more than sufficient number of cases to prove the real necessity of a nursing service, this seemed most unfortunate. Having missed any report from the nurse, and thinking that a talk with her might throw light upon the difficulty, the visitor asked to be introduced, but was told that she was not at the meeting, apparently because no one had thought to tell her that such a meeting was to take place.

In further conversation with the managers it transpired that most of them did not know the nurse by sight, and that, never having heard her describe her work, their sympathies and interests were only partially awakened.

How could they be expected to do the drudgery of money raising without the incentive of a conviction of the necessity of the task, and how could they feel this conviction without a personal knowledge of the nurse's do-

ings? Furthermore, without either this conviction or this knowledge, how could they be expected to guide her work intelligently?

In this town the mere regular attendance of the bright progressive nurse at the monthly meetings of the board worked wonders in no time, for the report of her work, and the simple stories told by her, brought home to the managers as no statistics had been able to do, the real meaning of what the nurse meant to the people.

Another association applied for help because of the difficulty of keeping a nurse. Four nurses described by the managers as "well recommended" had come, had done good work, and after a few months, apparently without reason, had decided to go elsewhere. The board of managers were greatly discouraged, because they were intensely interested in the work, and felt that they were paying a good salary and honestly meant to deal fairly by their nurses in every way.

At first the visiting superintendent was puzzled, but began to have an inkling of the truth when in describing the situation, manager after manager used the expression, "We never allowed Miss Blank to do this or that." A talk with the last Miss Blank revealed the fact that these excellent and executive women, in their zeal for detail, had allowed to their nurses less initiative than they would have been obliged to permit the cooks in their kitchens. They had in each instance apparently secured well-trained and experienced public health nurses but the nurses could not work happily, because of the stifling effect of being treated like children.

The final illustration is of a manufacturing town of some fifty thousand inhabitants which had been among the first to start a visiting nurse association. After many years of activity this association still employed but one nurse, who seemed not over-busy in spite of the steady growth of the city.

It naturally seemed that the trouble was probably with the nurse in failing to bring the needs of the people to her board. While in a measure this was the case, it was not by any means wholly the nurse's fault. During her first year of work there she had frequently reported that she found it difficult to meet the demands made upon her in even a ten-hour day. The response had always been that her predecessors had found no such trouble, and that with a little management she would undoubtedly be able to get through. On inquiry it became clear that the older members of the board of managers, those who for years had controlled the policy of the association, giving to it a beautiful and unselfish devotion, were, nevertheless, wholly uninformed as to the progress and development of public health nursing elsewhere.

They had taken for granted that each city had one nurse and no more, and were greatly shocked at what they felt must be the unhealthy conditions of the cities described by the visitor as making use of a large staff. Some vigorous reading on the subject of public health nursing, together with visits to neighbouring associations, produced a change of policy, and in an incredibly short time this city had a dozen nurses at work under a superintendent whose continued plea for more nurses was met by a board of managers as eager as she herself to supply the need.

Of course, where things have gone badly, the trouble has often lain with the nurse or nurses, who have been narrow-minded, or insufficiently trained for public health work. This in no way exonerates the board of managers, for in the final analysis it is the board which is responsible to the community for the care of the sick and the education of the well. They should so inform themselves of such work elsewhere as to have a uniform standard of excellence to apply to their own work, and should so know their nurses and superintendent of nurses, and their powers and limitations, as to be able to help them to their own

best development, or failing in this to make such changes as may seem best until true efficiency is secured.

In the long run, boards of managers can usually secure for their community what they most want. Therefore it behooves them to think well what they do want. In the modern rush and hurry and the rightfully insistent demand for efficiency, let them never forget that there are other things quite as important to public health nursing as even efficiency. Gentleness, kindness, sympathy, "love" in the Bible sense, are quite as necessary attributes in the public health nurse as ability, and if this fact is recognised by the board of managers, they will insist that such an atmosphere pervade the work.

If the board feels strongly about these things and leaves the selection of nurses in the hands of the superintendent, only a woman will be chosen for that position who has like convictions, and she in turn will not tolerate the absence of them in her nurses. Thus will be secured a combination of things material and things spiritual which cannot fail to have a far reaching effect on any city, town or country district.

CHAPTER III

THE SUPERINTENDENT OF NURSES

THE duties and responsibilities of the superintendent of a visiting nurse association are by no means simple, and their complexity and variety sometimes seem overwhelmingly discouraging.

This ought not to be so, for there is no more interesting work in the world than that incident to such a position, and the power of wise selection ought to be so exercised as to rid it of the terrors of undefined responsibility. The superintendent of nurses of a progressive association, if she is a wise woman, will frequently take time for meditation on the subject of her duties, for no human being could possibly meet all the demands likely to be made upon her. If she is to retain her peace of mind, elimination must not be left to accident, but must be the result of a carefully laid out programme, and a distinction must be made between necessary duties and merely desirable ones, for of both she will find an abundance.

The former, the necessary duties, naturally divide themselves into four groups: her responsibility toward the board of managers for whom she acts; her responsibility toward the nurses whose well-being and efficiency lie largely in her hands; her responsibility toward the patients for whom the whole organism is primarily existent; and her responsibility toward the community at large, which has the right to expect from her interest, co-operation and help at all times.

The value of a superintendent lies in the skill with

which she blends and fulfils these obligations, allowing no one to be met at the expense of the others, but maintaining the desirable balance which will strengthen all.

It is not surprising that the meeting the first of these responsibilities, that toward her board of managers, is apt to be a weak point in many otherwise excellent superintendents, because there has been very little in her previous training to fit her for this particular duty.

She is inclined to err in one of two exactly opposite directions; either she underrates the importance of a board of "merely lay" people, taking as a standard of value the things which she herself as a professional woman knows better than they, or she allows herself to become a mere servant of the board, failing to place at their disposal the knowledge which she possesses in fuller degree than they.

The nurse who is inclined to the former tendency should not forget that she is transitory while her board is permanent, not of course as regards individual membership, but as a governing body, and she must learn to value at its true worth the point of view of men and women who are, perhaps, authorities on other subjects, and who from the very fact of their relative remoteness from the problems bring to them a freshness of vision which may be denied the harassed nurse, eager with the desire for immediate results.

In her desire for sympathetic understanding, the superintendent must remember that she alone can impress upon the members of her board the vital realities which she describes.

Nine times out of ten, if she finds her board unsympathetic or lacking in enthusiasm, it is because she herself has been unsuccessful in so presenting the work as to awaken either their sympathy or their interest. Let her for a moment thoughtfully put herself in the place of members of the board. Let her be denied all direct con-

tact with the patients, all intercourse with the nurses, all the creative joys of administration, and give her instead the anxious task of money raising, and the impersonal task of legislation, and where would be her own sympathy and enthusiasm?

Her monthly reports to her board must be carefully prepared, whether they are written or not, and a great effort should be made to render them both interesting and informing. First of all, they must contain statistics, and these will never be anything but unintelligible to the average member of any board if they are delivered without comment. The fact that one thousand, six hundred and twenty-three patients have been cared for and six thousand, one hundred and ninety-two visits made means nothing to any one, but these figures assume significance if it is pointed out that in the previous year, during the same month, the number of patients was a hundred less, or that the additions to the staff have made possible a relatively larger number of visits per patient. Also a few words of analysis as to the types of case cared for are helpful. The fact that the number of obstetrical cases is increasing, or, because of the season much time must be given to the exacting care of typhoid, will prove interesting. Or, if tuberculosis or child welfare work is undertaken, relative statistics obtained from the city hall records as to cases of tuberculosis reported, or the infant death rate compared with statistics of previous years or of other associations doing similar work will make dry figures speak.

Anything which will accomplish this end is desirable for on the deductions that may be drawn ought to depend many of the legislative actions of the board.

In her report the superintendent must also try to make clear the things which have happened during the month, and in doing so let her be very honest. If difficulties have arisen which are in any way serious, the board should be told, even when no action is necessary on their part.

If, on the other hand, pleasant things have occurred, the board should have the advantage of hearing of them. A superintendent often goes on the principle, that because some part of the work is going well, no mention of it need be made. The result is that the hour of the board meeting is invariably spent in the consideration of woes, and the members go away with the mournful impression that the workers are always in trouble, and that visiting nursing is a very difficult proposition indeed.

This may be avoided if an effort is made to strike an optimistic note in the presentation even of difficulties, and by so balancing the items reported as to have something of a cheering nature to offset discouraging information.

Because of the necessity of attending to important matters of policy, there is a temptation to omit all mention of individual patients or stories connected with them. This is unfortunate, for with certain people the simple tale of one sick baby which has been saved is far more effective in arousing a desire to help, than the most carefully correct statements regarding the fall in the infant death rate.

Often these stories are best told by one of the staff nurses rather than by the superintendent, for the use of the personal pronoun in the telling makes it seem more real and vivid, and the presence of the nurse herself will stimulate helpful questioning. It goes without saying that names should never be used in the telling of these stories, even where it would seem quite safe to do so, for the right of the patients to privacy concerning their own affairs should be rigidly respected.

Though it is, of course, unwise to trouble the board with unconsidered plans or undigested ideas, it is wise for the superintendent to keep the members quite closely informed of her hopes and aspirations for future development. Often a cherished project which has been simmer-

ing in a superintendent's brain for a year or more will suddenly be presented to the board, and to her chagrin and disappointment it will be voted down, against her urgent advice. Had it been allowed to simmer in the brains of the managers for the same length of time, a very different verdict might have been given.

A statement, more or less casually dropped, that though the time is not yet ripe, sooner or later the board may be asked to consider such and such a project, or the description of a like venture elsewhere, will often pave the way for a more serious consideration of the matter later on.

One thing is certain, no superintendent must try to move more rapidly than her board of managers, for behind every action she must have the approval, not merely the antagonistic acquiescence, of her governing body. If she fails to gain this on matters of importance, let her take counsel of herself and decide whether she had best pursue a course of hopeful patience where she is, or seek a position under a board whose aims and methods more nearly correspond with her own.

Before coming to the latter conclusion she will, of course, try to make sure that her demands are not only reasonable in themselves, but reasonable in view of the local traditions and prejudices with which her board may be better acquainted than she is herself. On the one hand lies the danger of too hastily relinquishing a valuable opportunity for usefulness, and on the other, the possible good which sometimes comes from the dignified retirement of a nurse whose just demands have not been acceded to.

In any event perfect loyalty must be accorded the board, and in case of resignation, a quiet unemotional statement of the reasons for going should take the place of heated argument or recrimination. Nor should too great discouragement be felt by the superintendent thus retiring. All history shows that it is rarely the advance

guard which carries the citadel. To change the metaphor, it is on the foundation of the apparent utter failure of some of the finest men and women the world has ever seen that have been built most of the noblest structures of progress. Let no nurse feel herself unduly a martyr if, with the best intentions and highest ideals, she fails to carry her points. Let her rather study her own failure in the light of what little history the public health nursing movement furnishes, to see if with a deeper understanding of cause and effect she may not avoid some, at least, of the pitfalls into which she has fallen.

Of the four responsibilities of the superintendent which we have mentioned, that toward her board of managers requires, perhaps, her most thoughtful and vigorous effort. No part of her duty in this direction may be delegated to others, and both wisdom and creative ability are required in no small measure.

Half the failures to make the most of the unique opportunity to interpret managers to nurses, and nurses to managers, and the equally important one of making a whole work seem alive to a body of people not in direct touch with it, arise, not from a lack of ability, but because this part of a superintendent's work is not taken seriously. Too often the managers' meetings are looked upon as necessary, but unfortunate, interruptions to more important work, and the superintendent's contribution to them consists in a conscientiously exact, but deadly dull enumeration of statistics, and the gloomy statement that every one is overworked, or that the board of health is very trying. The unfairness of accepting as the unchangeable fiat of the gods decisions made by the board founded upon the insufficient information that she herself furnished them, does not occur to such a superintendent, and when these decisions prove unwise blame is placed on quite the wrong shoulders.

To sum up on this point we might say that a board of

managers has a right to expect of its superintendent an intelligent effort to understand its point of view, a fearless statement of the nurses' needs and requirements, and such carefully prepared reports of the work as will put them in intimate touch with all that is necessary in the way of general tendencies and detail, and which will constantly stimulate their interest and arouse their enthusiasm. In addition, they may rightly expect to be kept informed through her of such important developments in public health nursing as may be taking place elsewhere, in order that a wider horizon may give perspective to nearer details.

The second responsibility of the superintendent, that toward the nurses, is more tangible and simple than the last, and therefore somewhat easier to meet. While the power of leadership in its essence may be looked upon as a gift from heaven, like that bestowed upon the artist, the poet, or the musician, a few simple ingredients go into the making of a leader and may be cultivated to advantage by all whose duties include the management and control of others.

The first necessary attribute is justice, and without this all the other more agreeable qualities are almost valueless; a second is the power to see the work as a whole in which all the different parts are proportionately valued; a third is the orderliness of method which usually goes under the name of executive ability; and a fourth, almost necessarily included in the third, is the power to delegate responsibility. Through all these qualities must run the golden thread of sympathy, the quality which has the power to raise all work from the mere level of required duty to the heights of joyous service.

The same obligation rests upon the superintendent that rests upon the board of managers, the obligation to secure for the community an efficient, well-trained body of nurses doing good work, and the obligation to secure for the nurses

themselves healthy, happy conditions under which to accomplish this. The selection of nurses, therefore, should be given the most careful consideration.

The apt, if inelegant, statement of King Henry the Eighth as to the impossibility of making a silk purse out of undesirable material contains a real truth, and a superintendent will find that unless she can attract to her organisation nurses of a certain fine calibre, she will never be able to maintain the standard she desires. Two types of women as a rule apply for positions on the staffs of visiting nurse associations; a very fine type to whom the opportunities and nature of the work appeal, and a very poor type who have been failures at other kinds of work, or to whom the free evenings, and an assured salary, form the sole reasons for application.

Between the two, of course, are innumerable variations of the types which finally merge in the average specimen of the nurse who is capable of improvement under favourable conditions, or of equal deterioration under those which are unfavourable.

Just in so far as a superintendent is able to gather her staff from the type of nurse above the average, or to raise them to a higher level after acceptance, will her own duties and responsibilities be simplified, and her ends assured.

Intuitive knowledge of people is given by nature to some favoured few, but a careful study of character, based on what might be called observation of symptoms, will develop such knowledge in those to whom the natural gift has been denied.

In engaging new nurses, it is, of course, desirable to fill the ranks with those who will later have the ability to rise to higher positions. If this, however, were made an absolute rule, many really excellent and much beloved nurses would have to leave the field of public health work.

Executive ability, so necessary an attribute in the nurse

who takes charge of a district, can sometimes be dispensed with in subordinate positions on large staffs, and a nurse possessing the qualities of gentleness, cheerfulness, conscientiousness, and absolute devotion, so dear to the hearts of the patients, may be saved to the work. Quite as much skill may be exercised in the placing of nurses as in their selection or training, for if it is impossible to make a silk purse out of a sow's ear, it is quite as impossible to make one out of a material equal in value, but of different texture. A vast injustice is not infrequently done to a valuable woman by placing her in a position requiring qualities she does not possess and cannot acquire, and then judging her entire ability by her inevitable failure in this capacity.

A preconceived idea of what people ought to do, based on a principle which takes no heed of individual character and individual prejudices or weaknesses, is responsible for many avoidable failures.

The truth of which we have spoken in the preceding chapter, that no woman will work happily unless given opportunity for the development of her own personal powers, applies no less to the youngest nurse on the staff than to the superintendent herself, though the range for free initiative must necessarily be narrower.

Unquestioning obedience and conformity to rules are among the most important lessons learned by the pupil nurse during her hospital training, and make an indispensable foundation on which to build other desirable characteristics, but the superintendent who would have a really strong staff must not be content with a set of obedient children content to do her will, no matter how perfectly.

Her best security from the danger of an autocratic rule lies in the development of a body of women who will think for themselves, and whose ideas and theories are so valued as to become a part of the very warp and woof of

the association. In this way only can *esprit de corps* be developed, and in this way only will united strength be achieved. If these ends are gained, a superintendent may well feel that she can sing her *nunc dimittis*, for the welfare of the association will rest on no ephemeral advantages, nor on the personality of any single individual, but will be secure in the united strength of all its workers. Such a spirit will be contagious enough to quickly infect the newcomers, and in spite of a possibly changing staff, old traditions will be carried on, and thus assure the best elements of permanency to the work.

It is wonderful how easily a staff of visiting nurses can be made happy. So much of real joy for most of the workers lies in the work itself, that it is only necessary to remove a few of the hindrances to successful accomplishment, and to cultivate an atmosphere of sympathy and good fellowship, in order to have a happy and contented group.

Every effort should be made to bring the individual nurses and their work to the attention of the board of managers, in order that justice may be done their efforts and the stimulus of appreciation applied to them.

At any cost the office, or nurses' home, must be made a cheerful peaceful place which the nurses may look upon as a haven of refuge from the storms without, and where real fun and jollity will take the place of the depressing scenes so often encountered in the districts.

Difficulties will arise, for public health nurses, despite poems extolling their angelic qualities, are of very human material, and are quite as capable of being exasperated with each other as are any other group of people. A little judicious manipulation of positions and a resolute determination to prevent the insidious creeping in of an antagonistic spirit are usually sufficient to secure harmony. If not, it is better to part with a valued nurse, or pair of nurses, than to allow the development of opposing factions

within the association, which would in time undermine the whole structure.

The nurses' health is always a matter of anxiety to the superintendent, for the work is hard, and the exposure to weather great. A rule obliging the nurses to report minor illnesses at once, should be strictly enforced, and the nurses should be carefully watched. It will be found that, for the majority, eleven months of unremitting work is not possible. An extra half day, or a morning off duty in which to "sleep over," or even a few shortened working days administered at just the right moment, will sometimes save a longer sick leave.

There is not much danger of public health nurses becoming softened, for the exigencies of their work would seem a sufficient safeguard against softness in any form, and health is too precious a possession to be lightly jeopardised.

It goes without saying that, with a large staff, much of the oversight of the nurses will have to be left in the hands of others, but free access should always be possible to the superintendent herself, and every encouragement given to the discussion of difficulties.

If the superintendent has been successful in gaining the confidence and affection of her nurses, she is likely to be confronted with the temptation to exercise a somewhat despotic control over their affairs.

Let her draw a very sharp line between their personal concerns, over which she should exercise absolutely no control in any detail, and the affairs of the association, which are, of course, rightly her responsibility. If her advice is sought, and only if it is sought, she will naturally give it as would any other sympathetic friend, but such advice must not be allowed to assume the form of a command. Only when the nurses' personal affairs affect their work, or their influence in the association, do they become the responsibility of the superintendent. Paternalism, with all

its good points, has its grave disadvantages, and, in the long run, if applied to a group of visiting nurses will not be found to make for general happiness.

The third responsibility, that toward the patients, is one to which it is easiest for the superintendent to give herself, and the one to which it is least necessary that she should do so. Do not let us be misunderstood, or seem to underrate the importance of the patient. This book will have been written in vain if it fails to emphasise, first, and last, and all the way through, the fact that it is for the patient that all else exists.

The superintendent, however, does her work for the patients vicariously, and, though she may often wish it were otherwise, it is upon her power to place responsibility in other hands that the successful work of the association depends. A good superintendent early learns to delegate both responsibility and actual work, and to spend the time thus saved in the selection and training of those to whom this responsibility and work shall be delegated.

It is as bad management for her to concern herself with affairs which are not legitimately hers, at the expense of what she alone can do, as it would be for one of her nurses to neglect her patients in order to hear some interesting conversation in the office.

If a method of supervision has not been devised by which the nurses can carry their own responsibility without undue appeal to an already overtaxed superintendent, except, of course, in unusual situations which are important because they are typical, then the whole plan of administration is weak.

A superintendent thus deflected from her duties should apply herself to a strengthening of her nurses, or to a method of obtaining for them a better system of supervision.

We are not here speaking of a superintendent of only three or four nurses, whose legitimate responsibility just

such supervision may be, but of a superintendent of a large staff, who, because of a countless number of unnecessary distractions, can never be found at leisure to talk over some matter of policy with a puzzled nurse, or to properly prepare the monthly reports for her managers' meetings.

A superintendent must go out into the districts sufficiently often to keep her own sympathy and enthusiasm fresh and spontaneous, and to avoid the danger of guiding the nurses from an office-chair point of view, but beyond this the care given the patients should be dependent, not on her personal knowledge of their needs, but on her ability to choose the right nurses, and then to keep alight within them the divine fire of sympathy and the highest standards of efficiency.

If this is done the patients cannot fail to receive loving and efficient care, though in most instances the superintendent who has done so much to make this possible must forego the pleasure of the personal affection and gratitude which will naturally be accorded the nurses doing the actual work.

The last responsibility, the duty of the superintendent toward the community at large, is one full of complexity. This relationship is difficult because just in so far as her own work has been successful, will she find herself in demand for every kind of committee and meeting and conference. There will be a sweet reasonableness about each request for her assistance, because it is quite true that visiting nursing, touching as it does the home life of the people, is closely co-operative with a great variety of other activities.

Each demand must, of course, be decided upon individually, but though helpfulness and co-operation are most desirable, a certain moderation will have to be exercised if any time at all is to be left for home duties.

Here again, excellent results can be obtained by a wise delegation of these outside responsibilities. Members of

the board, or other nurses, may well be called upon both for committee work and the public speaking that is sure to be asked for. In regard to the latter, it is hard for many nurses who have had no experience whatever in such speaking, to accept the fact that it is really a part of their work. They might as well accept it first as last, however, and try to do it as well as possible. Some one has tried to encourage the timid speaker by saying that to achieve success he has but to observe three simple rules,—to stand up, to speak up, and to shut up.

Only the shy can appreciate the agony of spirit implied in obedience to the first rule, but many a wearied audience can testify to the number of untrained speakers who do not know how to make themselves heard or when to stop.

Half an hour is plenty of time for the average talk, and is longer than is accorded to many ministers for their Sunday sermons. Practice, and care in preparation of notes, together with a firm determination to follow the third injunction we have spoken of, will reduce the time required for saying what has to be said interestingly, and if all attempts at oratory give way to the simple desire to make the work known to the audience, this much hated task will become less irksome.

One duty to the people at large should be met by the superintendent herself when possible, and that is the listening to complaints. If every one with a grievance is made to feel that he has done the good deed that he really has, by bringing it to headquarters, much of the petty discomfort growing out of misinformation can be avoided, and the real troubles dealt with with dignity and fair-mindedness.

Time spent in explanations is time well spent, from the hour given to trying to make Giuseppi understand in the simplest English that it is highly improbable that Miss Smith, the most trustworthy nurse on the staff, has stolen the quarter of a dollar which Mrs. Giuseppi is quite sure

was beside the clock before her call and not there after it, to the still longer interview during which Mrs. Van Blank is allowed to give all her reasons why her special protégé is like no other patient, and should therefore receive a daily evening call.

The greatest asset an association has is the good-will of the community, and if Giuseppi and his class can be made to feel that it represents honesty and helpfulness, and if Mrs. Van Blank and her class can understand that necessary rules do not interfere with kindness and sympathy, these hours have been spent to the best possible advantage.

After this enumeration of the manifold duties of a superintendent, it may seem asking the impossible if we adjure her not to overdo. That, however, is to be the closing word on the subject of the superintendent of nurses. The wise arrangement of her time is, after all, merely a question of selection.

If she is to be the right arm of her managers, taking time to prepare for their meetings; if she is to know personally her individual nurses, selecting and guiding them thoughtfully; if she is to go into the districts at all; if she is to take some part in outside activities, and keep herself accessible to those whom she may help; it is obvious that she must be relieved of other duties. Nor is it enough that all these things should be fitted into her life like the pieces of a picture puzzle. She must have time to read, and time to think.

Let her, therefore, make it the rule of her life never to do herself the things that others can do as well, or almost as well as she. She should go to the office every morning, if possible, without a routine duty on her mind, or the more important things will be left undone because the merely necessary ones have to be attended to.

If she can keep her tranquillity, and do her work successfully, with one month's vacation, well and good. Few can, owing to the character of the work. If she becomes

fagged and discouraged by the multiplicity of her responsibilities, her association will buy back her enthusiasm and courage cheaply with a few days leave of absence as often as her particular physical and nervous make-up may require it.

In weighing the various demands made upon her, let no shortsighted spirit of self-sacrifice cause her to use herself up in the earlier years of her usefulness, lest, in those more valuable years which come later in life, the knowledge and experience that she has gained at so much cost may be unavailable because of physical disability.

CHAPTER IV

THE SUPERVISING OR HEAD NURSE

As the staffs of visiting nurse associations grow in size, it becomes increasingly difficult for either the superintendent or her assistant to give the personal supervision necessary to the work of the nurses. This is not only because other duties claim their time, but because the vast number of patients make it utterly impossible for them to grasp intelligently individual needs and requirements.

The necessity of assistance and supervision for the newer nurses being everywhere felt, the need has been met by the appointment of supervising, or head nurses. Though occasionally we find both supervising and head nurses working in the same association, the head nurse having no supervision of the work of others, the terms are as a rule interchangeable, both positions implying a responsibility for the work of a varying number of less experienced or less executive nurses.

This supervision is furnished in one of two ways: the supervisor may do no actual nursing; or she may combine her duties of supervision with a certain amount of nursing care of the patients. With the former method, there is usually one supervisor for a number of districts; with the latter, the supervisor herself has charge of a district which is sufficiently large to make necessary a number of nurses whose work and training are her responsibility. Whatever the method, the association looks upon its supervising or head nurses as the very backbone of its staff, and depends on them for far more than any actual work they

may do, or supervision they may give. As a rule, such positions have been given to nurses who have worked up from the ranks in the association, and who are, therefore, familiar with its spirit and traditions, and know working conditions as they actually exist. Let us see how such knowledge can be put to the best use.

The supervising nurse is relieved of all of the kind of responsibility towards the board of managers that exacts so heavy a toll from the time and effort of the superintendent of nurses. Matters of general policy, while claiming her interest and occasionally her advice, are never matters of final decision for her. In the place of these comes a responsibility toward the association as a whole, and toward the superintendent of nurses as representing its administrative side. In addition, the three other responsibilities, which in the last chapter were assigned to the superintendent, fall to the lot of the supervising or head nurse, though with a different emphasis and in modified form. There is the responsibility toward the nurses working under her, the responsibility toward the patients, and the responsibility toward the outside world with which her work brings her in contact.

In the first place, it is impossible for any supervising nurse to do good work in an association with whose aims and general methods she is not in sympathy. As she is not in a position to greatly affect the general policy, if it is radically opposed to her own ideas she had best decide to throw in her lot elsewhere, for, above all, unity of purpose is necessary among those who guide and influence the rank and file of the staff.

It would be almost better to teach the nurses to do the wrong thing with the right spirit, than to teach them to do the right thing with the wrong spirit, although fortunately such a choice of evils is not necessary.

Neither the association, which is composed of human beings, nor the superintendent, who is made of the same mor-

tal clay, are perfect. Certainly we have no wish to kill the power of discernment in an intelligent woman, but there is a great difference between a clear opinion as to errors of judgment, and a spirit of antagonism or disloyalty. If the latter feelings exist among the supervising nurses, rottenness is at the heart of the fruit no matter how fair the outside may appear.

Influence is not always rated at its true importance. Unless loyalty to the association is the guiding spirit of the supervisors it is hopeless to expect to find it in the other nurses. Without loyalty, there cannot be unity, and without unity — good work is impossible.

To the superintendent of nurses the supervisors owe, in addition to loyalty and an effort to impress on the nurses her ideals and methods, a very honest and frank report of the successes and failures of those working under them.

Successes are easily told, but the fear of tale bearing and a mistaken idea of kindness sometimes cause a suppression of unfavourable information which practically renders the usefulness of the supervision negligible.

The one supreme effort should be toward honesty and justice in the faithful representation of facts, for without the help of the supervising nurses the superintendent is powerless to build up a strong staff, imbued with the spirit she desires. Nor should the supervisor suffer unduly because of the sometimes unhappy consequences which befall an offending nurse, following the revelations of failure she has thought it necessary to make. She may comfort herself with the thought that the results of her conscientiously given information are in no wise her responsibility, but belong to those higher in authority than herself.

All serious mistakes or wrong doings are as a rule the fault of more than one person: the nurse who commits the bad error; the supervisor who did not see and report that she was the kind of woman likely to fail in such a way;

and the superintendent of nurses who has not instilled into her supervisors the necessity of proper observation and reporting. Of the three, the nurse who has spoken the unkind word to the patient, or made the mistake in treatment, is perhaps least to blame, because more may be expected of the other two, and yet as a rule it is she alone who suffers the penalty of the action. Let the supervising nurse, therefore, at least free her conscience by an earnest effort to place at the disposal of the superintendent all helpful information which will aid her in the difficult task of administration.

In the responsibility of the supervising nurse toward the nurses working under her supervision, we have a demand not unlike that made upon the superintendent of nurses. There is one great difference, however, a difference not always appreciated by the supervisor. She is relieved of all final decisions, and also of all questions of general policy regarding them, and being thus relieved she can give herself more unreservedly to matters of detail connected with the nurses' happiness, health and efficiency. The less sharply defined line, too, drawn between her position and that of the staff enables her to draw nearer to the nurses than is always possible for the superintendent.

The supervisor, therefore, will do well to apply herself to a study of the various personalities assigned to her for supervision, with a view to gaining a just estimate of their powers and abilities, and the knowledge which will enable her to give her help in the best way.

She will quickly learn that the kind of stimulus needed by one nurse is often ineffective when applied to another.

A word of encouragement brings all that is best in Miss A. to the fore, while Miss B. has to be constantly, though courteously, reminded that she has not as yet grasped all of the principles or mastered all the procedures of public health nursing. Miss C.'s timidity needs reassurance. Miss D.'s progressiveness and tendency to free-lance work

must be wisely curbed. In her zeal for that most fascinating of all exercises, the management of people, the supervisor must not have a mould of her own making into which she tries to run the varying characters with which she is brought in contact. She must, on the contrary, have no mould at all, but simply try to help the nurses to help themselves to their own best development, and in this effort let her seek constant counsel of her superintendent. Time cannot be better spent than on such consultations.

Tact and the right spirit, will make the nurses look upon their supervisor as a friend and helper, and this relationship once established, supervision is made simple and natural, and the expression of well-considered criticism is easy.

It sometimes seems to a superintendent that her nurses are divided into two types, which, for want of better terms, may be called agitators and non-agitators. In the agitator's district there seems always to be trouble, or, if not trouble, something to cause excitement, and the general impression gained is of overwork, bustle and disturbance. In the non-agitator's district peace prevails, and though there as elsewhere, things go wrong, an atmosphere of tranquillity and leisure is never lost. It is not until these nurses have been moved about, or have changed districts, that it becomes clear that the conditions of work may be identical for both types of nurses, and yet that one type will continue to be agitators through life while the tranquillity of the other is equally unaffected by outside conditions.

When the supervisor is an agitator, it has been found that no matter how popular she may be the nurses dislike to work under her, and the superintendent who is looking for it will be able to trace much of the nervous exhaustion of the nurses to this particular quality in one placed over them.

Because these agitators are apt to be women of mental

and nervous alertness, and because their lack of tranquillity is often mistakenly ascribed to efficiency and progressiveness, the serious drawbacks to their methods of work are not always realised, and the contagion of agitation is allowed to spread throughout a whole group of women.

The nurse thus inclined should be vigorously dealt with by her supervisor, and a quiet recital of her difficulties insisted upon in place of the excited accounts she likes to give. If the agitator is fortunate enough to possess a sense of humour, it can be brought to her aid in changing her mental attitude, for nothing is more amusing than the whirlwind entrance of such a nurse, her breathless account of the wrong doing of every one, and her final exit for a renewed dash to her district. Though laughable for once, such excitement is wearing in the extreme, and cannot fail to react unfavourably on the patients, though they themselves would be wholly unable to assign a reason for their increased nervousness after the nurse's visit.

Second only in importance to the wise dealing with personality is the power to delegate responsibility. A supervising nurse cannot be, and she ought not to be, everywhere at once, but because she is not, there is no reason why anything should be less well done. The hospital has in a measure taught this lesson to its pupil nurses while in training, but the nurse who has charge of a district, or as supervisor, charge of several districts, will be an utter failure unless she puts such lessons in daily practice. She must not only know how to wisely delegate her own responsibility, but she must teach the nurses working under her in turn to delegate theirs to some member of the patient's family capable of assuming it.

Miss Nightingale in her wonderful little book, "Notes on Nursing," with which, by the way, every nurse should be familiar, makes a number of pertinent remarks on this subject.

She says: "To be 'in charge' is certainly not only to carry out the proper measures yourself, but to see that every one else does so too; to see that no one either wilfully or ignorantly thwarts or prevents such measures. It is neither to do everything yourself or to appoint a number of people to do each duty, but to insure that each does that duty to which he is appointed."

Miss Nightingale has little patience with any of the excuses usually offered by those who are weak in this power of giving over their work to others.

To quote again from the "Notes on Nursing," "People who are in charge often seem to have pride in feeling that they will be 'missed,' that no one can understand or carry on their arrangements, their system, books, accounts, etc., but themselves. It seems to me that the pride is rather in carrying on a system, in keeping stores, closets, books, accounts, etc., so that anybody can understand and carry them on, so that in case of absence or illness, one can deliver everything up to others and know that all will go on as usual, and that one shall never be missed."

While these wise words apply to every type of leader, whether it be a woman managing her own well-ordered household or the head of some great business enterprise, they are particularly applicable to the public health nurse, the very nature of whose work implies her inability to be constantly with her patients. What is done during the twenty-three hours that the nurse is not there, is just as important as what takes place during the one hour that she is there. A lesson which has not been learned cannot be taught, so let it be the earnest effort of every supervisor to thoroughly grasp the fact that only by intelligent delegation of responsibility will a self-reliant set of nurses be trained up, and the continuous good care of the patients assured.

The arrangement of work will next claim the supervisor's attention, and on her ability to do this well will

depend much of the comfort of her nurses. It is, of course, impossible to give any general advice as to method or system. It can only be urged that thought and time be given to the matter and that nothing be left to haphazard happening.

In some associations a great effort is made to give always the same nurse to the same patient. In others it is thought that better results are gained, both for the nurses and the patients, by a change. There are some types of chronic cases which it is very hard to care for day after day, sometimes year after year. Such cases, usually, do as well or better with an occasional change of nurses, and the burden falls less heavily on any one.

Supervisors will, as a rule, find that they obtain the best results for their nurses by meting out to them a fair share of carefully considered responsibility for which they will be held strictly accountable, and by then allowing a very free hand as to method. Part of the work of a supervising nurse is to train other supervisors, and this will never be done if responsibility is withheld from them.

As regards the teaching of bedside care, the nurses of course, have had their hospital training, but they will require assistance in the adaptation of hospital methods to tenement or home nursing. This is best done by demonstration rather than by precept, care of course being taken that the patients are not made to feel that they will be nursed by one who does not know how. Nor is it enough to merely teach proper methods of procedure. Unfortunately few human beings are capable of a sustained excellence without constant oversight. If, as we believe, a high standard of nursing skill and a careful attention to detail are the only foundation stones on which good public health work can rest, the supervisor must realise that she cannot relax her vigilance in regard to the actual bedside care given to the patients by her subordinate nurses.

The subject of pupil nurses will be dealt with in a later chapter. Where pupils are sent out from their hospitals to an association for training, they become a special problem, and when such training becomes the responsibility of a supervisor, it will necessarily occupy a good deal of her time and thought.

The manifestation of the responsibility of the supervising or head nurse toward the patients will depend somewhat on whether she has charge of a district in which she personally gives nursing care or whether her duties exclude nursing except for purposes of instruction. In either case she has a wonderful opportunity, for not only can she bring help and comfort to those whom she actually serves, but she is in a position to reach a wider field in her power to impress upon others her ideals for such service. As her own work in the homes, when that is part of her duty, is identical with that of the staff nurse, it will not be spoken of here. In the apportionment of calls, however, she will do well to make first visits herself, and to see all the cases sufficiently often to keep a knowledge of their condition and situation fresh in her mind.

Because of the greater number reached, perhaps the most important service the supervisor renders the patients is given through the effect of her precept and example on those working under her, who in turn pass on to the patients what they have learned. If in receiving reports, sympathetic feeling, gentleness, understanding, hopefulness and humour are encouraged, these qualities will be developed in the nurses, to the great advantage of their patients. If, on the other hand, impatient judgment, ill nature, discouragement, or lack of appreciation of suffering are permitted, these feelings can never be kept wholly out of the homes.

The righteously indignant or justly irritated nurse needs a sympathiser, and often a backer, in her supervisor, but such help will best be given by an effort to raise the

whole situation above the level of irritation and personal indignation.

Some patients and their families require a firm hand if they are to be really helped, and the child will be spoiled if the rod of discipline is withheld. The use of such a rod, though it may even entail the temporary withdrawal of the nurse, may be found the only means possible of dealing with some conditions, but it should be very carefully handled, and only wielded from the one motive of good in the long run for the patient. The dangers of the use of disciplinary measures are to be more feared for the nurses than for the patients, because of their slightly hardening effect on the mental attitude. The opposite of hardness, however, is not weakness, but softness, a virtue in no way opposed to strength and clearness of judgment.

If the supervisor fits herself to see deep into the causes of the failures of her patients, she will be able to help the nurses to a point of view which will strengthen their powers of dealing with difficult and trying situations with wisdom and firmness, without in any way weakening the softer and gentler sides of their natures.

The demands of the poor are often unreasonable in the light of their poverty, but a little thought will show any impartial observer that what they want is what any one would want under like conditions. If the nurses can be made to see this, their understanding will enable them to eliminate all seeming unkindness from their inevitable refusal to accede to the patients' wishes.

As regards the actual nursing care of the patients, it goes without saying that the supervisor should try to provide this in its utmost perfection. It has been proved that, with knowledge and initiative, really excellent care can be given under the most adverse conditions, and it is for the supervisor to set and maintain such a standard as will assure to the patient the maximum of skill and comfort.

The last responsibility, that toward the various outside agencies and individuals with whom the supervisor comes in contact, will claim rather more of her time than she will probably at first expect. She should not, however, account such time ill-spent, for it is on her ability to deal wisely with all those whom the work of the association touches that much of its well-being will depend.

Therefore let her accept as legitimate and important parts of her work the talking with doctors, the calls on co-workers, the interviews with those who want to help, the listening to complaints, and the public speaking that may be asked of her.

In this relationship an appreciation of the value of co-operation, and a large amount of plain common sense, are the things most necessary, applied with what New Englanders call "pleasantness." Without pleasantness the sterner virtues do not always find favour. With it, even common sense becomes agreeable.

It is generally accepted as axiomatic that to see the other man's point of view is the secret of co-operation, but in the course of daily work the ability to make the other man see yours is certainly not of less importance. The greatest successes the public health nurses have gained, have been won by the exercise of just this power. Sometimes such understanding is brought about by personal interviews and careful explanations; sometimes, and this has been the case with many doctors of the less progressive type, by patience and a quality of work which in time wins confidence. It is inevitable that to a work which by its very nature involves the effort to lead in new paths, such understanding should not always be accorded. When it is not, no bitterness must be allowed to creep in, but the work should be continued with courage and independence. If a rock impossible to climb over is in the way, no false pride should prevent a circuitous route round being taken.

It is not too much to say, however, that at least a good

proportion of the co-operative woes under which public health nurses groan are those of their own making, and could be avoided by a little more tolerance and understanding, a little more patience and effort to see the other person's point of view, a good deal more time given to explanation, and a cultivation of that afore mentioned pleasantness, the lubricator of so many creaking wheels. It is only when all these have been tried to the uttermost, that the nurse may have the honour of donning the martyr's robe and joining with cheerfulness and hopefulness the great army of those who have been permitted to suffer for a cause they love.

Will the supervising nurse have time for all these activities? To guide her nurses wisely, taking thought not only of their work, but of their training and health and happiness; to bring to the patients the care they need and the sympathy they long for; to be that link between the association and the general public which is one of her most important functions; and having time for all these things, will she be able to so avoid overwork as to keep herself in good physical and nervous condition? If she feels constantly pressed let her bring the fact to the attention of her superintendent of nurses, and with her help try to make a distribution of her time which will make possible the retention of the essentials in her day's work.

CHAPTER V

THE STAFF NURSE

THE evolution of public health nursing in cities has naturally made necessary a much more complicated organisation than is required in small towns or in the country. The number of nurses must be increased to meet the demand of the large number of patients; superintendents and supervising nurses must be appointed for the double purpose of arranging and supervising work, and of relieving the staff nurses of duties not included in their legitimate task of home visiting; while for the same reason, office help must be furnished to reduce to the minimum the time spent on clerical work.

As we attend national conventions, and become part of the large audiences gathered together from the majority of the States of the Union to discuss and consider public health nursing subjects; as we visit the busy offices of the big city visiting nurse associations, and see all the necessary paraphernalia of an active business enterprise; as we have correspondence with state and city boards of health employing hundreds of nurses; as we meet with boards of managers, composed of men and women giving time which in many instances is of great financial value, it is interesting to consider what all this is for.

Reduced to its simplest expression, all this machinery exists for the sole purpose of bringing care, instruction and sympathy to the home of Mrs. A., Mrs. B., and Mrs. C. and that care, that instruction and that sympathy are

brought there by the staff nurse, and the staff nurse alone.

In other words, all the vast machinery we have spoken of is valueless without the nurse who brings her ministrations to the homes, and the fact that the single home is multiplied till it reaches into many millions only changes the situation so far as it further emphasises the importance of the actual point of contact, the nurse.

Because the public health nursing movement in its progress has gathered so much administrative detail, and because the co-operativeness of its nature has involved it in so many issues, the quiet little nurse working away in her own corner sometimes forgets the fact, that everything exists for the sole ultimate purpose of making it possible for her and for others like her to do home visiting in the best way.

She is the centre. With her began public health nursing when, under Mr. Rathbone's sole guidance, she started the work in Liverpool. With her as the centre, it will continue as long as public health nursing is needed. And public health nursing will be approaching its end when the details of organisation and administration, the necessary forms and ceremonies, are allowed to obscure the fact that what really counts is the planting and tending of the tree, which "when the desire cometh is a tree of life." Many things enter into the beautiful mystery of growth, but the tools of ministration and instruction, the actual trowel and spade of the labour, are placed in the hands of the nurse who herself enters the home, and to her the whole organism must always look for the results of all its complicated effort.

Let no public health nurse, therefore, feel that she bears an unimportant part in the great work of the movement. Let her rather rejoice in the dignity of her position, and rightly appreciate the fact that thousands of men and women in this and other countries so honour it, and so rate its importance, as to be willing to spend freely of their

time and thought and money in order to build for her such a foundation as will enable her to do her work to the best advantage.

We shall speak of the nurse who works alone in another chapter, because her duties and responsibilities differ somewhat from those of the nurse who is a member of a staff and working under a superintendent. For the latter, the complexity of city work would make satisfactory home nursing impossible unless she were relieved of many of the responsibilities of administration which form part of the work of her country sister.

In most associations the staff nurse has no anxiety as to funds, no care of supplies, as little clerical work as possible, and is not held responsible for the work of other nurses. All matters of general policy, too, are out of her hands. Thus relieved, her time can be almost entirely given to her work in the homes, but such work must not be allowed to fill her whole horizon. She will never advance the usefulness of her association if she feels, that because such sharp emphasis is placed upon her work with her patients, it is possible for her to do that work as if she were a lone individual stranded on a desert island.

It would seem unnecessary to dwell further on the value of team work, for the staff nurse who has read the preceding chapters must apply to herself every word that has been said on the subject. That the association is strong in the unity and loyalty of its staff does not mean something vaguely desirable. It means that each nurse must so want the things the association stands for that she is ready to sink her personal likes and dislikes, her personal preference and irritations, in a general effort to work well on the team.

If she is not happy or feels that she has just cause for objection, let her go frankly to the right person, her superintendent, and tell her the whole difficulty, and let her keep her lips very tightly closed on the subject to the

wrong persons, the other nurses. If every one complains ever so little, a sum total of complaint will quickly roll up quite capable of creating a most uncomfortable atmosphere, and such complaint is utterly impotent, for nothing is righted in that way.

Every nurse should do her part to establish personal relations with her superintendent and supervisors and form her own opinion of their desire to help her and make her happy. Not infrequently a nurse will go to the superintendent with a simple request which is most readily and gladly granted, and it will transpire that for months she has refrained from making known her desire because some one else has been refused a totally different request under totally different conditions. Almost every superintendent very honestly desires the happiness, as well as the welfare, of her nurses, if indeed the two terms are not synonymous, and will be glad of the opportunity to act the part of a friend if she is permitted to do so.

As regards the important relationship of the staff nurse to her colleagues, the other nurses, a word must be said. It is natural and inevitable that some personalities will be mutually attractive and others just the reverse, and while a nurse may have the pleasure of working with a friend whose every action is satisfactory to her, her work on the other hand may bring her in contact with another who is antagonistic in every way. Neither of these situations must be allowed to affect her spirit or her work, for both have the power to do so adversely, the former no less than the latter. An intimate friendship may be allowed to become so absorbing as to quite seriously affect all the other relationships of life, and every superintendent knows the discomfort that such friendships are capable of producing in a staff. The other nurses are made to feel intrusive when their work causes them to interfere with the friends, all enthusiasm goes from work which must be done apart, and woe follows the arrangement of free after-

noons which does not permit that they be spent together.

All this is as subversive to good team work as antagonism, though in a more subtle way. If life is to be happily and successfully lived the art of working with other people must be mastered, and though to some enviable natures no effort is required in the mastering, for the average man and woman it is something that must be taken seriously, and both hearts and heads brought to bear on the effort. A general acceptance of the basic principle that all the nurses want, and work for, one thing, the best care of their patients will bring about, first tolerance, then patience, and finally appreciation and understanding of different methods of attaining the common end.

In considering her patients, the nurse who would do the most good must take into account their social, as well as their physical needs, and the knowledge to do this is not acquired in a day, nor can the social needs be met by the nurse alone.

As the hospital teaches observation of physical symptoms, so the districts teach observation of social symptoms, and for the latter, as for the former, the power to see what is there to be seen, has to be cultivated.

As grave an error is committed by the public health nurse who fails to notice that a child of school age is always to be found at home in school hours, as the one who has not noticed that the patient's pulse is more rapid. In neither case is she expected to take active measures herself, but in both she is expected to notify the proper authority. In the one case the situation is simplified by the fact that it is always the doctor who is the proper authority, while with social symptoms the proper authority may be one of many agencies or individuals. A public health nurse on this account must form the habit of getting below effects to their causes.

Though the truant officer might seem the proper person to deal with the child out of school, if the cause of the

absence is the fact that there is literally no one else to take care of the younger children during the mother's illness, it would be useless to call him in. The proper authority in this case may be no farther away than the husband who, if appealed to, could make arrangements with a friendly neighbour which would straighten the whole matter; or it might, on the other hand, be one of several charitable agencies. In any event the important point is the fact that the nurse knows three things: first, that something is wrong; second, why it is wrong, and third, what can be done to set it right.

To the nurse beginning public health nursing it sometimes seems as if an impossible demand were to be made upon her, but as she goes on with her work the observation of social symptoms becomes second-nature with her, and once she has accustomed herself to see them, the other steps come more easily. She cannot enter a house without gaining a very clear idea as to its sanitary condition, and whether or not there are enough rooms, and enough beds to harbour decently the members of the family and any boarders they may take. She knows what care is being provided for the patient and if any one is being taxed to the breaking point in order to provide it. She knows whether other members of the family are in good physical condition, and if the children of school age are in school. She knows if the husband has steady work, and how many other members of the family are working. After a very few calls she learns if any of the children are wayward, or given to truancy. The sad tale of drunkenness comes out, or tiny straws tell the even sadder one of immorality.

All these things the experienced public health nurse knows with hardly the necessity of a question, as she knows that the patient whose white little feet were washed carefully the day before has been out of bed if she finds black little soles in the morning, no matter what may be said

to the contrary, and knowing them, she has but to learn the ropes to set in train other influences for the good of the family. Results will not always be satisfactory, for too many doubtful elements enter into every social dilemma to insure success for the best laid plan, but the nurse will have done her best if board of health, charity organisation, truant officer, children's aid society, settlement house, priest, minister, employer, or friend have been made use of as required.

She must, of course, steer a straight course between an undue interference and the necessity of rendering assistance that is not always desired. As a child may not want to go to school, counting as naught the education which later will mean so much to him, so many a grown-up child does not want to be helped to better conditions of living.

Due allowance must be made for the habits of a lifetime and time must be given to effect any radical change, but much may be accomplished by tact and perseverance.

All nurses are familiar with the patient who at first rigorously objects to his bath, and all are equally familiar with the indignation of this same patient if later, after he has learned to enjoy it, his bath is delayed in the stress of work. Many other things are like the baths, and once accepted become matters of course, but much, infinitely much, depends on the personality of the nurse presenting the new point of view, and the manner in which she presents it.

If her patience does not always hold out let her reverse the picture and imagine herself without the intelligence that has been developed by her education, being persuaded by some one, perhaps younger than herself, of very likely an alien race and an alien language, to do something that neither she nor her ancestors have ever dreamed of doing before. Add to this the not unnatural attitude of suspicion engendered by generations of political oppression,

and the wonder will be found to lie not in the failures, but in the successes of public health nurses.

The zeal of the new nurse will usually make the management of her day's work a little difficult. She will find it hard to calculate her time, and she will be beset by the thought of a thousand little services by which she could make her patients more comfortable. These, when she cannot get them in during prescribed hours, she may try to perform by increasing the hours of her working day, or by going without her lunch. If these methods are objected to, she is apt to find it hard to reconcile such an attitude with real sympathy for the needs of the patient or his family.

Here let her give a little time to thought, and try to see the work of the association as a whole, as her superintendent is obliged to look at it. She, too, would love to provide all the little, not absolutely necessary, things for the patients, but the situation is not a simple one. On one side are a certain number of sick people to be nursed, a certain other number to be taught by instructive visits, a certain number of clinics or baby consultations to be attended, a necessary amount of clerical work to be done, and if the nurses' powers are to be developed, time given to meetings or lectures.

On the other side is the great difficulty of procuring sufficient funds, and the necessity of so arranging the work as to make it possible to perform it within hours, and under conditions which can be maintained year after year to every one's advantage.

It is not for the nurse who is in a position to see but a very small part of the broad field of the association's activities, to make herself the judge of its methods. She would far better fall quietly in with the routine mapped out for her, conforming to all rules, and suspending judgment until a ripper experience enables her to form a wiser opinion.

Of one thing every nurse may be certain, her superintendent and supervisors are in thorough sympathy with her desire to do more for her patients than they give her time to do, and if she is restrained, it is because they must try to meet the heavy demands of the work for the whole city, or possibly because they want her to learn the important lesson of teaching others to help themselves. When it is her own time, not the association's, which the nurse wishes to spend, it often seems unreasonable that she should be prevented from doing so. While thoroughly appreciating the motives which prompt such a wish, most superintendents have found, that in the long run, the patients receive the best care from a staff of nurses whose enthusiasm has been kept fresh by a strict protection of their free time except in emergency or under unusual conditions.

Therefore, the nurse who is thwarted in her desire to do some extra service for her patient must not allow her ardour to cool. She must, on the contrary, make additional use of it during the usual working hours, sure of the fact that this same enthusiasm is not undervalued by those in authority over her.

The habit of promptness in the arrangement of work will greatly facilitate its accomplishment. The temptation is great to make one more call in the neighbourhood at about the lunch hour, or to make a few extra friendly visits at the end of the day, but once yielded to, this temptation leads to a poor system of work. Emergencies will, of course, arise, but it has been found that on the whole the best work is to be had from the nurse who begins on time, who stops promptly at the appointed hour, and who arranges to take her luncheon quietly and peacefully at a regular time each day. The experience of thousands of good nurses has proved that this is possible, and that the nurse who never has time for her luncheon, and who is found constantly working overtime, is not more de-

voted to her patients than others, but is merely a poorer manager.

Thus far we seem to have dwelt somewhat at length on restrictions, but no one need be discouraged; there is ample opportunity for devotion and self-sacrifice within the eight hours of the usual working day.

Four things the patients require of the nurse who would serve them; skilful nursing, instruction of the family which will insure their care during her absence, hopeful sympathy, and assistance in acquiring such things other than nursing as they may need.

The first of these things, the skilful nursing, is sometimes so taken for granted that sufficient emphasis is not placed upon it. A perfect organisation, a fine board of managers, a good superintendent, and a staff of nurses with additional diplomas from the best schools of philanthropy in the country may be accounted as valueless if the patients are not kept clean, and their dressings antiseptically and thoroughly done; and in saying this, we have no wish to undervalue administrative excellence or social training. Nor is it enough, that the mere minimum of good nursing care should be given in the districts. Because of the opportunity for instruction, and because the patient must be left for so many hours without trained care, every nicety of nursing must be brought in play. To those accustomed to the ameliorations of illness in the houses of the rich it is often a revelation what can be accomplished in the poorest homes. Many a district patient after the nurse's call may be found in as exquisite a condition as the most carefully tended private patient, excepting for the unimportant details of fineness of linen and luxury of surroundings.

Experience develops the power of the nurse to work with what she finds provided, and also makes her more successful in securing the essentials from the family. What these essentials are, will, of course, depend on the

patient's condition, and what he has been accustomed to. Fresh air, clean bed clothes and a clean room, enough of the right kind of food properly prepared, quiet and regularity of hours for the administration of food and medicine, would seem perhaps, the minimum of requirements. But in trying to procure these requisites the nurse must remember that she is often expecting a revolution of method in the household. Fresh air, if cold, is disliked; cleanliness may never have been considered important, quiet has probably never been considered at all, regularity and system are in many cases unknown terms, and the lack of suitable food may be due to both ignorance and poverty. Therefore great patience is necessary, as well as tact and persistence.

A wise nurse will make use of her knowledge of people, for often some person can be discovered possessed of that something, which under other conditions would be called executive ability, on whom real dependence can be placed. It may be the natural care-taker, the wife or mother, it may be the husband, it may be a neighbour or friend, or it may be a mere child.

Whoever it is, much of the comfort and well-being of the patient will depend on the nurse's discovery of such ability, and the use she makes of it. As has already been said in a previous chapter, the hours during which the nurse is away are just as important to the patient as the hour she is with him, therefore the instructions as to his care which she leaves behind her have a very vital effect on his welfare. Such instructions should be given very simply and to the right person. If, as is probable, they include moving the patient, or any form of treatment, the one who is to give such care should be carefully shown how to do it, not merely told. If on subsequent visits commendation is freely bestowed, the nurse *pro tem* will be encouraged to further effort.

A very real danger in the rapid development of public

health nursing lies in the removal of responsibility from those who would naturally care for their sick. The nurse must try to foster, never kill, the desire to help, and she must learn to recognise this desire under the disguise of many queer performances, and make use of it, for after all, it is the inalienable right of every individual to serve their own in sickness and trouble. Pride in nursing prowess can easily be awakened, and with an able colleague in the house everything is simplified.

Quite as important, however, as instruction in actual care, is the atmosphere with which a nurse is able to surround her patients in her absence. Nervousness or nerve exhaustion are part of almost every illness, and because they are so little understood many a poor patient has been made to suffer miserably and most unnecessarily. If the condition of racked nerves is discussed as seriously with the family as some of the other more readily understood physical symptoms, and if alleviative measures, such as quiet, absence of worrying conversation, loud talking, etc., can be insisted upon, convalescence will be found to proceed much more rapidly. If in addition, sympathetic kindness can be made to replace the irritation, or joking intolerance, so often meted out to the nervous sufferer by a well intentioned family, the nurse will have done much to ease the burden.

Not infrequently, where the case is a chronic one, everybody has, perhaps not unnaturally, grown tired of the situation produced by the patient's suffering, if not indeed, of the suffering and of the patient himself. The genuine interest and sympathy of the nurse, together with a little adjustment by her which will somewhat shift the burden of care, is often sufficient to fan the flame of family affection into life again.

It is something for the nurse to remember that she may be, and often is, the only bit of brightness which enters the patient's room during all the dreary twenty-four hours.

If kindness, sympathy, hope, and a little fun enter with her, the whole day is changed, and for old people and chronic invalids this often means changing what remains of an earthly lifetime.

It is usually taught in hospitals that a nurse should not intrude her own joys or sorrows on her patients. For the public health nurse, such advice cannot be wisely given. Her value lies largely in her power to gain the confidence and affection of her patients. And who is going to confide in or grow fond of an impersonal being who gives nothing of herself in return? Of course, it is not meant that a nurse should be foolishly unreserved about her own affairs, but a little of her delight at an approaching vacation can be shared with a patient who is capable of feeling an unselfish joy in her pleasure, or her own anxiety about an elderly mother may be so spoken of as to open the heart of an overworked daughter, as no mere effort to give comfort is capable of doing.

For the same reason, though the personal acceptance of money by the nurses is universally prohibited by associations everywhere, it is felt that the little gifts sometimes made by loving hands are quite a different matter. The spirit that prompts these offerings would be killed by a refusal to accept them, and would bring an artificial element into what is a very sweet and simple relationship.

By a study of her people the nurse may learn many ways of bringing pleasure into barren lives without taxing her time unduly. One patient may be made to feel that she has really spent the hour of the nurse's visit at the moving picture show as she listens to the account of something the nurse has seen the night before; another may get a breath of the outside world through a description of the spring styles in the shop windows, or even by a graphic account of the nurse's vicissitudes in buying her own Easter bonnet. To others, either of these things would seem frivolous, but a few moments' forgetfulness of

suffering may be obtained if they are encouraged to describe customs or conditions in their own far away home country.

A little knowledge of human nature helps wonderfully. The nurse who planned a birthday party of three for a bed-ridden patient added the most important touch when, in addition to the beautifully frosted cake, gorgeous with name, date and candles, she carried a bag of lady fingers to eat with the ice cream. What would have been the good of a wonderful cake which was merely eaten, and not displayed to the neighbours? What matter if, after two weeks of envied possession, it was almost too stale to cut when at last it was distributed to admiring friends? Through the rare joy of pride of possession, the pink candles and the nurse's thoughtfulness were the means of bringing a little light into a darkened life.

Such seeming trifles should not be scorned. No one without the experience of a long illness can perhaps realise the importance of trifles in a day which holds nothing else, but pain and weakness and anxious thoughts.

Convalescence is a time of great difficulty with the average district patient, and here many otherwise good nurses, and we might add, good doctors, fail.

As far as the economic value of the individual goes, he has none, from the first day he is ill to the day of his return to a perfectly normal life, yet, half way through an illness, usually soon after the danger point has been passed, every one seems to lose interest in his recovery. Not nearly enough attention is paid to convalescence in hospital and private nursing, but in the district home the situation of the convalescent is often pitiable in the extreme, and some of the best work of the nurse may be done at this period of a patient's illness.

The objective should always be the complete recovery, nervous and physical, of the patient, and his return in good condition to a normal life, and the nurse's work is

no less valuable when it is done through advice, rather than by personal ministration. For this reason, many associations believe in carrying cases no longer needing bedside care until convalescence is far advanced.

In procuring for her patients material assistance, the nurse new to public health work will need to submit herself very strictly to the guidance of those under whom she works. An incalculable amount of harm can be done by unwise giving, and there are few visiting nurses who have been long at work, who cannot trace the downward path of some family to the time when in their unwisdom, they procured for them material aid not really needed, and which they would have been far better without.

This brings us to a word about the pay question. It is generally conceded that, while free nursing care must be given to those who cannot pay, a fee for such care should be charged to those who can afford it, according to their means. The decision as to the financial situation is usually left to the nurse, and there is probably no part of her work which is so hard or so distasteful. The decision as to the ability to pay is difficult; the decision as to the amount that can be rightly afforded is difficult; and the actual task of collecting the sum decided on is difficult. Indeed, there is nothing easy about it, but the rule that payment should be made has not become a general one with all associations, without careful consideration, and the nurses may comfort themselves a little by the thought that their difficulties are most truly appreciated by their superintendents and supervisors.

There is one weakness, like many others the opposite of a virtue, which is likely to be found in some of the best nurses. The intense interest aroused by certain patients not infrequently so fills the mind of a tender-hearted nurse as to claim for them an undue proportion of her time and attention, to the real injustice of others less appealing. Sometimes, too, the intensity of the interest

burns itself out, and the very patient who has received in the beginning more than his due ends by receiving less. It is the steady, even, dependable care which produces the best results for the individual, and it is the justly apportioned interest and devotion which produce the best results for the district as a whole.

In dealing with the doctors with whom she is brought in contact a nurse will have an opportunity to use her powers of adaptability to the full. She will meet very varied types of men, but to all she must accord a true loyalty. It goes without saying that she will have her personal preferences, but such preferences must not be allowed to be felt by the patients, and an open mind will often discover much real ability where it is least looked for.

In her relations with physicians, and also with other agencies, the nurse who informs herself of the rules governing what is known as professional etiquette, and then by a real spirit of co-operation tries not only to get help for her own work but gives her aid freely to the work of others, seeing only the common end, cannot go far astray, for she will not fall into the fatal error of feeling that unaided or unaiding she can do much for her people or her cause.

The question of the kind of interest in her association which will make the nurse really thrifty and economical in the use of supplies, may seem of little importance. If, however, she has reached the point when she and the association work as one, she will not be economical because she is told to be, but because she will realise that a little wastefulness on the part of each nurse makes a big aggregate and cuts down the association's powers of usefulness by just that amount, adding at the same time in equal ratio to the anxiety of those responsible for the financial situation. Let her put the question to herself, "If I gave

a dollar to public health work, would I be willing that it should be spent for gauze which is wasted, or in replacing articles which need not have been lost or broken?" The right use of donated funds is a responsibility which should be felt by the youngest nurse on the staff.

Because public health nursing is so absorbing, many nurses defeat their own end by giving their entire selves to it, and, by so doing allow other parts of their nature to become dwarfed and atrophied.

St. Vincent de Paul gave this wise advice to Mlle. Le Gras, who had charge of the first Sisters of Charity, "Be careful of your health and be careful not to overdo. It is a trick of the devil by which he deceives good souls, to entice them to do more than they can, and so make them unable to do anything at all." In these modern days, living not in a sequestered community but in the midst of this rushing twentieth century world, it is difficult to so adjust one's life as not to succumb to this particular wile of the devil.

If the nurse is to see her work with any perspective at all, she must see it through reading or lectures which will take her outside the four boundary lines of her district, and if she is to gain a like perspective for her life as a whole, she must get away from her work altogether in her free time, that she may receive from people, books and places unconnected with it, a larger horizon. Play, of the kind suited to each individual, is as necessary, if good work is to be done, as food, and should be planned for with as much care.

To the nurse with a healthy body, and a nature kept fresh and sane by outside interests, the opportunities and privileges of the work are unbounded.

A labouring man who was heard to say, "I feel like standing with my hat off when a visiting nurse passes me in the street," not only expressed his own reverence for

what he had known one nurse to do; but the reverence which all who know the work intimately must feel for the opportunities implied by the uniform.

If the great body of staff nurses, in this and other lands, can meet their responsibilities humbly and happily; giving to their associations a first rate loyalty; to their superintendents, a genuine effort to understand and assist them in the task of administration; to their colleagues, kindness, and an effort to strengthen their hands; to the doctors and other workers, not only a strict adherence to the rules of professional etiquette, but the touch beyond which will make them more helpful; and to the patients, that loving care and sympathy so potent for changing stricken lives, all will be well with public health nursing, for it will be builded upon a rock.

CHAPTER VI

THE NURSE WORKING ALONE

IN many instances work is started in a small place by a nurse who has had experience as member of a city staff, or has taken a post-graduate course in public health nursing, but to whom the inauguration of work in a new field is an untrodden path.

In taking up her duties such a nurse must be prepared to consider the health problem of her community as a whole, and while never forgetting the individual welfare of her patients, she must give time and thought to many things beside bedside nursing. Her work is likely to prove full of interest, because of the variety of duties which she will be called upon to perform. As she is usually the only nurse at work she will be at once a general visiting nurse, a tuberculosis nurse, a child welfare nurse, a school nurse, a mental hygiene nurse, a sanitary inspector, and a leader in all health interests.

It must be confessed that this would sound somewhat appalling were it not for the fact that hundreds of nurses are actually to be found who are performing these multitudinous duties successfully and with apparent ease.

Public health nursing in rural districts or small towns is usually undertaken by a nurse working under the auspices of a state or county health board or by a nurse representing the staff of a visiting nurse association and who may or may not be a Red Cross nurse. The work of the state or county nurse differs somewhat from that of the nurse working under a visiting nurse association in that

she is without a board of managers, though it will be greatly to the advantage of her work if a special nursing committee or bureau has been placed directly in charge of it.

The nurse working under the control of a visiting nurse association whether she be a Red Cross nurse or not must expect to give time to the administrative side of her work. If the association by which she is engaged is just being started, a certain amount of leadership is necessary in dealing with the board of managers, and there is one point upon which every nurse should insist, namely, that regular meetings of boards or committees should be held. Sometimes the members of an association which has been formed with considerable enthusiasm will feel that they have done their part when, with great effort, the necessary funds have been raised, and a nurse found to do the work. On her arrival they are quite ready to leave everything to her, saying politely that she is to call upon them in case of need, but not, as a matter of fact, expecting to attend meetings or to do anything, except in emergency. This, if the nurse permits it, is fatal to a strong and safe organisation. If no emergency arises, and the nurse is resourceful, things may slip along, with perhaps occasional irregular meetings, but when the second year arrives and the budget has to be met, no one is particularly interested in bestirring themselves to secure it. Or when the looked-for emergency arises, and the nurse calls her board together, she will find that, having followed her efforts so little, they are too far behind to really understand or answer her call for help intelligently.

Regularity of meetings, therefore, should be the nurse's first care, for without such regularity she is so helpless as to be quite justified in declining to continue a connection with an association unwilling to do its part for the public health of its community.

Having secured her regular meetings, her second care

should be the use she makes of them, for they must be looked upon as opportunities, not as interruptions to other work, and made the most of as such. This will take time and thought.

The members of the board are called together to assist her in what she is trying to accomplish, but they can only do this successfully if they are kept intelligently informed of her efforts and plans. It is unnecessary to speak further of the relation of the nurse working alone to her board, for such relationship differs little from that of a superintendent of nurses to her governing body, of which we have spoken at length in Chapter III of Part II. The city-bred nurse, however, in dealing with a country board, must realise that when there is a difference in the point of view it is her board which probably represents the attitude of mind of the community, and the same is true when a nurse goes to an unfamiliar part of the country which has different local traditions from those to which she has been accustomed. She need not always give up her own point of view, but may so present it, and so adapt it, as to make a good working basis on which she and her board may proceed. Many an otherwise good nurse has failed because of an inability to understand conditions which were new to her. A Northern nurse working in the South will accomplish nothing by ignoring the question of colour. A Western nurse must try to understand the importance of tradition in an Eastern village. North and South, East and West have much to bring to each other, but the gift will only be acceptable if wisely bestowed.

The importance of suitable and accurate records must be recognised from the start. Slack methods of record-keeping are of the past, and the necessary blanks which will save the nurses' time in recording data, will be found an economy, not an extravagance. Statistics as to rural health are often sadly lacking, and a very valuable con-

tribution may be made to the knowledge of health conditions in country districts by the nurse who interests herself in the subject. In addition to records which deal with the patients' health such statistics should be kept as will make possible a thoroughly business-like system of bookkeeping whereby an intelligent knowledge of the expenditure of the funds in relation to the work done may be obtained. All records, no matter how simple, should be kept up to date, so that necessary information may be obtained in a moment, and also that in case of illness or sudden absence the situation may be clear at a glance to a substituting nurse.

The first difficulty of the nurse who goes from a well-organised city association to start work elsewhere will be her lack of patients, and her later difficulty, their overabundance. It takes time for any new idea to take root, but while she must have patience, it is not enough for her to sit peacefully down and wait for cases. The unoccupied time of the first few weeks can be spent to the best possible advantage in laying a good foundation for her future work. If her association sends out a short written or printed notice to every physician, explaining the work of the nurse, and stating under what conditions her services may be obtained, and how to communicate with her, it will be a great help, but it will not usually be enough. A personal call on each doctor will do more to establish comfortable relations than any amount of printed information.

And here let us give a word of warning to the nurse fresh from her post-graduate course, or with her years of city experience behind her, who, because it wears an unfamiliar garb, may not recognise the very thing she is looking for. She will, perhaps, be possessed of untold stores of knowledge, and be fairly alight with the fire of instructive zeal, but these claims to ability are not always the best introduction to the medical practitioner, who has

never seen a visiting nurse before. Her peculiar form of social training may seem to him of little worth, while the instructive zeal is either amusing, or terrifying, according as he belittles or magnifies its importance. What he wants, if he is to have a nurse at all, is "a good honest woman, who will keep his patients clean and do just as he says."

Such a doctor is quite justified in his conservative attitude. For years, he has probably worked faithfully and well among his people, often finding efficient assistance in some good experienced nurse or intelligent member of the patient's family. It is most natural that the new visiting nurse should be obliged to win her spurs before he gives her his confidence.

Instead of feeling a hopeless despair because her training and ability to instruct are unappreciated, let her set herself to gain his approval, not by over-much talking or an effort to change his point of view, but by showing him that she is the honest woman, capable of giving thorough baths and obeying directions, that he is looking for. When these facts have been established in his mind, he may be ready to show her that he, too, is not so ignorant of social subjects as he seemed at first, though he may not use the latest terminology, and that his unremitting, though perhaps half unconscious efforts to teach the people how to keep well, have produced results which have had their effect on the entire community. Of course all doctors are not of this type, and with some the nurse will never work sympathetically, but as we have reiterated, the rules of professional etiquette must be none the less observed. It is far better in the beginning to err on the side of an over-scrupulous observance, than to gain a reputation for an easy morality on this subject. A nurse undertaking new work is sometimes heard to say, "Here I have to be so careful with the physicians, but in ——— all the very best doctors allowed me to use my own judgment

for many of the minor things." Such a nurse forgets that these men after years, perhaps, of experience with her had proved her powers, and also that behind her she had the strength of an association which had grown to be a civic force. This strength, the nurse striking out for herself, often misses, though she does not know what is wrong. Prestige is an intangible thing, but for the nurses working in established and valued visiting nurse associations, it smooths more rough roads than they ever realise until without it, they try to make themselves felt on their own merits alone.

In working with the doctors it is wise to take whatever is offered in the way of co-operation. With some it will be the generous-minded welcome accorded a co-worker, with others, merely a grudging tolerance hard to accept. The nurse, however, who is able to feel that her services are being used by all the doctors of her community, even though the terms of such co-operation may not be altogether to her liking, can well congratulate herself on her success.

After the physicians have been called upon, it is well for the nurse to make herself acquainted with the other workers of the town or village, and here she must again be careful.

She must forget her desire to teach, and become a humble learner at these interviews, for the advice and information she may receive will be most helpful. Even when her opinion is sought, let her be a little wary in expressing it. She is sure to be quoted, and further knowledge of conditions will often modify an early opinion.

Above all let her be careful not to be drawn into any of the local feuds or disputes which sometimes flourish so amazingly in small places, which, if entered into, would curtail her usefulness to an opposing faction. This she may do quite unconsciously and in ignorance when she is a stranger, unless she is on her guard to avoid it.

She will, of course, make her own friends, and should be as free to do so as any other private individual, but nothing must be allowed to interfere with her usefulness to all, and she must remember that the dignity of the association is increased or diminished through her.

During the first weeks she may also make excellent use of her spare time in a study of town hall statistics. A comparison with those of other places of the same size will tell her whether the infant death rate is relatively high, and by them she may learn in what houses deaths from tuberculosis have occurred, if typhoid is epidemic and if so in what localities, and whether contagious diseases have been devastating in their effects. The health officer may be a great help or a real hindrance to her work. Which of these he becomes will somewhat depend upon her first approaches to him. In all these efforts to get started the nurse must be careful not to adopt a critical attitude, or, still more irritating, a patronising one, and above all, she had better move slowly. What can be done peacefully in her second year might produce a tempest if attempted in her first.

It will be a good plan for her to take the time to sit quietly down, and, after due thought, write in her notebook all the things she would like to change or inaugurate, dividing these into three groups: those that she can bring before her board or superior officer at once, asking that measures may immediately be taken about them; those that she may wisely mention with the advice that for the present no steps be taken; and those that for a time she had best keep to herself. She will do well in the very beginning to make the first list a short one, the second longer, and the third the longest of all. By constant reference to these lists she will avoid the danger, on the one hand, of alarming her board and the community by her radicalism, and, on the other, of allowing herself to drift with the tide, taking the line of least resistance and fail-

ing to make use of the opportunities within her grasp.

A good nurse will quickly learn to distinguish between situations which are typical and those which are isolated. The former must be dealt with with great care, for they are foundation stones on which future progress is to be built, the latter are comparatively unimportant and a point may often be stretched to advantage in dealing with them.

Unless she works under state or county control (in which case all the taxpayers will naturally be entitled to her services), the nurse's attention will be early claimed by the so-called pay question. Who is to pay and who is not? Most of the large city associations in introducing the system of payment have laboured under the disadvantage of being obliged to do so by means of an unpopular revolution, as almost all of them established in the earlier years of the movement gave free care to all cases. This was true in England as well as in America, for Miss Hughes of the Queen's Institute writes, "In tracing the development of district nursing it is evident that the mediæval idea was revived, that the nursing of the poor must be an act of Charity, and all the original associations were founded on this basis." ¹

The results of such a policy, and its subsequent change, have made a hard and difficult row for the nurses to hoe. It can never, perhaps, be made an easy proposition while we have a sliding scale, but it will be much simplified if the nurse starts in the right way.

Any community will be as ready to grasp the idea that a nurse is being provided at cost price, or at a cost within the means of those whose incomes are small, as that a free nurse has made her appearance. It is better that the non-payment cases should from the beginning be looked upon as necessary exceptions to a general rule, rather than that

¹ Amy Hughes, "District Nursing on Provident Lines."

the paying patients should feel they are making use of a charity nurse.

Absolutely free care should be given only when the nurse considers it a necessity, but when given, the gift should be so cordially bestowed as to leave no taste of bitterness in the mouth of the recipient.

The question of what patients should be cared for by a visiting nurse is sometimes a difficult one in a small community where private nurses are not easily obtainable, and there has been a curious evolution of thought on the subject. At first the district nurse was considered the peculiar property of the very poor, and no account was taken of those of moderate means even though they could not afford to obtain trained nursing in any other way. Gradually the needs of this class have been put on a paying or partially paying basis, and so successful has been the work of the visiting nurse that there is a dawning desire to make use of her systematised skill on the part of those who, though they could afford it, do not require the continuous care of a private nurse. On this threshold we have paused, fearful lest, if the time of the public health nurse were to be given to those who could afford other care, the poor, the very class for whom the nurse is primarily intended, would suffer.

This fear is no foolish one. It would be only too easy to drift into a disastrous state of things, wherein those needing most would receive least. In a small community with but one nurse, where adjustment of time is difficult, this danger is very real.

If the nurses' services are to be placed at the disposal of the whole community, irrespective of income, two things must be borne constantly in mind. First, that the patients most needing care should receive it first, and second, that any work done among those in comfortable circumstances should be absolutely self-supporting. This latter necessity should be no mere matter of guesswork,

but such records kept as will make the situation perfectly clear on this point. In reckoning expense of service, not only salaries should be considered, but all expenses incident to running the association, the rent of headquarters, supplies, substitutes' salaries, transportation, uniforms, convention expenses, in short, the complete annual budget. If this is done there will be no temptation to allow the poor to suffer because of an over-busy nurse, for nurses can of course be added to meet the demand whatever it may be.

The question of night work in places where there is no hospital, and where private nurses are not easily available always comes up. No woman can do both day and night work at the same time, and as day work, the house to house visiting of the sick, is the real object of the association's existence, night work should only be done as the rarest emergency when the question seems one of actually saving a life.

It is far better to do well what the association has undertaken to do than to attempt anything which will weaken the accomplishment of that purpose. It is a great temptation for a thoroughly interested nurse to spend the night in the house of a critically ill patient, hoping to snatch enough sleep to enable her to manage her next day's work. In the long run such a course will produce poor work, if not a physical breakdown. Far more will be accomplished by the discovery of a reliable woman who, either with or without remuneration, will take an occasional night of duty. A small fund may be established for such payment among the very poor, but the nurse used to city methods must be careful not to break down the neighbourly habit of offering friendly assistance in times of trouble, which fortunately still exists in many country places.

Occasionally a board of managers, unfamiliar with the usual methods of conducting public health work, feels

that because private nurses combine considerable night work with their day work, a visiting nurse should be able to do so too. The nurse may remind them that, because this is so, the private nurse is obliged to charge much more for her services than a public health nurse, in order that between cases she may be able to take time for complete rest and relaxation. Also that the demand on the private nurse is a very uneven one, entailing great stress of work at one time, followed by periods of far less activity at others. The public health nurse, on the contrary, must go freshly forth, equipped to do creative work, each working morning of the year, and for this she must have a rested body and rested nerves. Where night work must occasionally be done, provision should be made for rest on the following day.

There are, of course, rural districts where the distances are very great, and where even the doctor is often unavailable. These make a law unto themselves, for the work is necessarily quite different from that in villages or small towns, and must be done under different conditions. In such places a nurse, to be useful, may be obliged to spend a day or two with a critically ill patient, as it would be wholly impracticable for her to leave and return to him again. Her work, like that of the private nurse, may be very uneven, a rush at one time, and comparative leisure at another. It would be as absurd to insist on the usual methods for these districts, as to expect city conveniences. We can only urge such a nurse to look over the whole field of her activity sufficiently often to keep a broad outlook, and to remember that she has no right to allow herself to break down.

Sunday duty is everywhere difficult to plan for, but the nurse must arrange to reduce the work as far as possible on that day, seeing only the cases which would suffer if she omitted her call.

Sometimes the doctors form a habit of performing

minor operations on Sunday, because it is for them a day of greater leisure, operations such as the removal of adenoids, circumcision, and others of a like character about which no haste whatever is necessary. If the nurse finds herself constantly in demand for such Sunday work, she had better talk the matter over with her nurses' committee, or board of managers, and ask that a courteous letter be written to the doctors explaining the attitude of the association toward Sunday work.

The nurse working alone will probably have, beside her already sick patients, a certain amount of advisory work with tuberculosis cases, mothers of babies, school children, etc., and in the stress of actual nursing this advisory work is apt to be slighted. This should not happen, for it is of the greatest importance. In the first place the nurse must try to inform herself of the development of these special branches of nursing elsewhere, in order that she may not make use of obsolete methods in dealing with them. Both she and her board should consider this as a necessary part of her work, and a part which must rightly take its share of her time. If she cannot do justice to her advisory work she should confer with her board, and not allow them lightly to confine the activity of the association to the care of the already sick. Nor should she stop here. A knowledge of sanitation is now considered an important part of a public health nurse's education, and some of her most valuable work may be done in changing unsanitary conditions. To this end health clubs may be formed and talks given which will pave the way for more direct attacks on local sanitary abuses.

Perhaps the most difficult position in which a nurse working alone finds herself is when, the preliminary steps having been taken, her efforts at advertisement and co-operation take effect, and after a period of ever increasing activity she wakes up to the fact that she has more

work on her hands than she can possibly accomplish satisfactorily within prescribed hours. Knowing the difficulty of raising the funds, her heart sinks at the thought of asking for help.

Confronted with this difficulty many nurses bravely try to struggle on, keeping long hours, slighting the less acute cases, taking no time for thought, and losing the enthusiasm that is such a vital asset to good work, and in the end reaching the state of mind in which the forest is so completely hidden by the trees as to be non-existent even in imagination.

In spite of the pluck, which we must admire, such efforts merely delay a change of policy, and the nurse is making a mistake of judgment in her apportionment of responsibility, arrogating to herself an undue share. The care of the sick, and the teaching on health subjects in any community, are the responsibility of the community itself. The community is represented in the matter by the association, which in turn vests its administrative responsibility in its board of managers. As the board of managers is itself manifestly unable to nurse the sick, a nurse is engaged to do this according to certain methods and under certain conditions which years of experience all over the country have proved productive of good results. A self-sacrificing nurse must not forget that the general rules governing hours and methods of work have been evolved and developed, not with a view to making a pleasant life for a group of nurses, but in order that the sick may on the whole be nursed to the best advantage.

The nurse whose work develops beyond her power of accomplishment under these general rules, should not, therefore, feel that on her shoulders rests the responsibility of finding a way out of the difficulty. On her shoulders does rest the responsibility of drawing so clear a picture of the need of the work and how and why she is failing to meet that need that her managers will be able

to act in full knowledge of the situation. Beyond this her responsibility does not go. If the nurse has carried her board with her, step by step, in the growth of the work, it is probable they will feel that the increased demand must be met by yet more vigorous efforts on their part to wake the community to its responsibility concerning public health, and the necessity of supplying the funds necessary for its development.

If this is not done, there should be a definite understanding, and the nurse should assist her board in the construction of a method of limitation which can be consistently carried out, keeping always in view the hope that it may be temporary. It is well, also, to make generally known the fact that a curtailment of work has been financially necessary, for who will make the effort to buy a larger pair of shoes unless they feel the pinch of the pair they are wearing?

We all know that times have, as we say, changed; that railroads, telegraphs, telephones, cheap postal facilities, newspapers, etc., have brought all the world nearer together. The statement is a truism, and yet, not infrequently, a public health nurse is found making her daily rounds as if no such state of things existed as far as her work goes. All by herself she tries to solve each new problem as it comes up, oblivious of the fact that this very problem has probably been solved in a sufficient number of other places to make a safe precedent to be followed, or that a national organisation exists for the very purpose of helping nurses situated as she is.

It is no longer enough to do one's own work well. A public health nurse is not an isolated unit trying to meet unique conditions in some particular locality. She is, as we have tried so often to express, part of a large and important movement which is making itself felt all over the world.

Attendance at national conventions should, if possible,

be considered a necessary part of the running expenses of an association, if not every year, then as often as can be arranged for. If the nurse who has enjoyed the privilege of attending a convention comes back to her board with old ideas crystallised by comparison with the ideas of others, with new methods and suggestions, and full of an enthusiasm so contagious as to be felt by every member, money spent in expenses will have been well invested.

No nurse should ignore the value of magazines dealing with public health matters, or the strength that comes through membership in nursing organisations. Local public health nurses' clubs, meeting to talk over public health nursing matters help tremendously, and can be formed with the simplest of organisation.

If the nurse is in so remote a place as to be denied all intercourse with other nurses, let her not be afraid to lift up her voice by correspondence, and ask for the help she needs. The National Organisation for Public Health Nursing stands always ready to answer questions, and it is safe to say that it would be hard to find a public health nurse, be she the superintendent of a large city association or a quiet nurse working alone, who would not account it a privilege to be allowed to pass on, for the help of others, any experience she may have gained for herself.

Those who have the stimulus of what Phillips Brooks has called "corporate courage," meaning the courage that is sustained by that of others, usually take it as a matter of course. It is not until a nurse leaves a band of other nurses, and undertakes single handed to deal with her manifold problems, that she realises how much her own courage has been kept up by the courage of those about her.

A story has been told by an executive secretary of a national nursing organisation, of a letter she received asking what the necessary expense would be for her to visit a tiny Western town. As the secretary was at a dis-

tance, the expense was considerable, and time hard to spare. Arrangements, however, were finally made. The secretary was in the habit on such trips of being asked to speak at meetings, large or small, but in this instance her hostess evidently had no such intention for she proposed to take part of the long journey herself, meeting the secretary at a point midway. Full of curiosity, the secretary set forth, and the interview, a long one, took place in the station at the meeting place. In telling the story, the secretary said, "I found an eager sensitive little nurse, filled with the enthusiasm of her calling, trying to meet alone a most difficult situation, and almost at the end of her courage. She so aroused and interested me by her story that I must have been able to give back to her some of the inspiration I felt, for at the end of our interview she assured me that seeing another nurse who could understand her point of view and sympathise with her ideals, had helped her so much, as to make far more than worth while the heavy expense of the journey."¹

The pathos of the little story may find an echo in the heart of many a lonely nurse, for loneliness of purpose or ideals may be felt even in the midst of the warmest affection from patients, and the sincere appreciation of a board of managers.

Such lonely nurses must take comfort in the feeling of sisterhood which ought to be felt by all public health nurses, and also in the thought of how greatly their work is esteemed by those who realise that their own problems are wonderfully simplified by the companionship of other nurses.

Miss Chloe Jackson, in an article on the organisation of tuberculosis work, makes so excellent a summing up of advice to the pioneer that we quote it for the benefit of those who are starting any kind of new work. "First,

¹ These words of the late Miss Isabelle McIsaac's are quoted from memory.

don't quarrel with your town or county, don't criticise your public officials, don't take refusals to help as being personal affronts. Don't remember past refusals or past difficulties, don't worry, and don't fail to ask the same people the next time you need help. Don't get excited, don't allow your feelings to be harrowed by suffering or need in any direction, don't think that nothing can be done. Get ready before you start, don't fail to stop and look and listen before you do the next thing. Don't take up any work unless you feel that you can do it and make it go. Don't allow yourself to be a martyr or a failure. Don't fail to do the little things in a big, comprehensive, far-reaching fashion. Don't allow discussions in meetings of work that can't be done, or people who won't help, or officials who refuse to take your advice. Make suggestions but reserve your judgment."¹

¹ Miss Chloe Jackson, "Organisation of Tuberculosis Work in Small Cities and Counties." *American Journal of Nursing*, October, 1912.

CHAPTER VII

THE PUPIL NURSE

THE question of training in public health nursing for the undergraduate nurse is an extremely difficult one on which to speak at this time, because we are in so transitional a state of mind as to its advantages and disadvantages.

The question has three aspects: as it affects the pupil nurse, as it affects the work which she undertakes to do, and as it affects the hospital training school.

For the pupil it is a question of education. She goes to the hospital for the sole purpose of gaining for herself the training which will best fit her for her future work as a nurse. If a portion of her time is spent in the district, instead of the ward, we must ask ourselves whether she is thereby gaining the equivalent of hospital experience. As regards the work done by her, it is a question of whether the individual patients are best served in this way, and the cause of public health nursing furthered by the training of undergraduates for the work. For the hospital training school, it is a question of fulfilling its obligation towards its pupils in the broadest way, and at the same time meeting the practical difficulties of administration.

A number of nurse educators feel that a thorough and complete training in public health nursing ought to be obtainable before graduation by nurses who desire it. They advocate classes and lectures based on a social interpretation of sickness extending throughout the entire pe-

riod of training, which will prepare the ground for practical work in the district in the third year, if the pupil so elects. Others are convinced that the hospitals are already attempting the impossible in their effort to give specialised training, and that nurses desiring to fit themselves for public health work should expect to do so by means of post-graduate courses. A third group takes a middle ground, and believes that, while a complete public health training may be impossible until after graduation, a sufficient amount of theoretical work may be given during the period of hospital training to open the eyes of the pupil to the possibilities of public health nursing, and that a few months of her time may be spent to advantage in gaining from district experience certain things which the hospitals cannot teach.

There has been a temptation, too often yielded to, on the part of struggling visiting nurse associations to gain for themselves an extra nurse without expense, by asking for a pupil from one of the local hospitals. No injustice is intended, but only the point of view of the association is considered, and an increasing number of calls without a correspondingly increasing income drive the directors to this means of solving their problem. Bare experience is mistaken for training, and no one, unless it be the superintendent of the training school, sees the wrong principle involved, least of all the pupil herself, glad of a change of work, and too ignorant of educational standards to appreciate the situation. An undergraduate nurse is not a pair of hands to accomplish work, but a student engaged in gaining her education, and if she is always so regarded her exploitation becomes impossible.

As yet no hospital training school has made the attempt to give to its undergraduate nurses a complete training in public health nursing in any of its forms. The difficulty of providing such training is well-recognised by all public health nurses, but so colossal is some-

times the ignorance of the young graduate on subjects connected with community health or the social causes of illness that the Committee on Public Health Nursing Education of the National Organisation for Public Health Nursing has this year (1916) made certain suggestions in regard to undergraduate training. These suggestions were made with a view to giving to pupil nurses not a training in public health nursing, but some insight into subjects, a knowledge of which will tend to broaden their outlook, and prove of value to them in whatever line of nursing work they may take up. The Committee proposed that during the first year a slight turn be given to the pupil's mental attitude by a course of five lectures on sickness as a social problem, and also by a few days spent in the social service department of their hospital or with a local visiting nurse association, in order that the home conditions of hospital patients might be visualised.

In the second year the lectures usually given on the physical aspects of the various diseases could be supplemented by others dealing with tuberculosis, venereal diseases, mental diseases, etc., in their relation, not to the individual, but to the community. In the third year the Committee recommended a series of, perhaps, fifteen lectures, five on the special branches of public health nursing and ten on such modern social problems as labour conditions, immigration, prostitution, housing, etc. For the training school so organised that it can offer electives to a few carefully selected students it was felt by the Committee that elective courses given in affiliation with local public health activities are desirable.

Were such theoretical work arranged by the hospital, the problem of providing practical training would be greatly simplified. Many associations which have conscientiously done their best for pupil nurses sent to them for training have felt deeply their inability to teach the theory on which public health nursing procedures rest.

For the training school wishing to provide practical training in the districts for its pupils, two methods are open: the pupil may be sent directly from her hospital into the homes of the patients, supervision being provided by the training school; or training may be obtained by means of affiliation with a visiting nurse association. The danger of the former method lies in the fact that such nursing is apt to be a side issue with the hospital, and that the broader aspects of public health nursing will not be recognised. It should never be undertaken without provision for special supervision. A busy superintendent of nurses of a training school cannot carry on her own work and at the same time do justice to this highly specialised and rapidly developing branch of nursing.

In some hospitals excellent public health training is given in connection with an active out-patient department, supervision being provided by a permanent graduate nurse especially fitted for such a teaching position. Under her pupils may be placed to advantage. In special hospitals, such as those for tuberculosis, obstetrics, or mental cases, where home visiting is done, pupils may also be sent out with advantage to themselves, though for all forms of advisory work, undergraduate nurses have as a rule, been found undesirable. The constant changes are prejudicial to the work, and only selected nurses are capable of doing it well, even after prolonged experience, while the time allowed the pupil for such training makes excellence impossible. Unless a hospital is especially equipped, either because of its special nature or its active out-patient or social service department, to teach not only home visiting, but the larger principles involved in public health nursing, it would do well to secure training for its pupils through affiliation with a good visiting nurse association, whose business it is to keep up with the better, and standardised, methods of public health work.

Where visiting nurse associations exist, the method of

affiliation has also the great advantage, which cannot be too strongly emphasised, of unifying the public health nursing of the city or town. Nothing is more disadvantageous to broad development than the existence of a number of nurses, working independently of each other, with different standards and methods of work. Overlapping, or failure to cover the entire field, can hardly be avoided.

In arranging for affiliation the training school, in justice to its pupils, should assure itself of two things: first, that the association is employing modern and approved methods of work; and second, that systematised and educative supervision will be guaranteed the pupil during the entire period of her connection with it. It is usual for the association to so arrange the pupil's time as to permit of her return to the hospital for all lectures and classes, and no stress of work should be allowed to interfere with this arrangement. The nature of visiting nursing will, of course, be understood by the hospital, but the association will naturally be expected to surround the pupil with the usual safeguards against its dangers. The full working time of the nurse should be required by the association during the period of affiliation. If she is expected to go on duty in the hospital after her day in the district, she will not only have the added fatigue of such additional work, but there will be a divided interest which is undesirable. Also such an arrangement provides many possible points of friction which are better avoided. The pupil usually continues to live at the hospital, while the association is responsible for carfare and all expenses incident to her work, providing also the uniform hats and coats. In many cities the pupil wears her own probation dresses, though occasionally the hospital provides uniform dresses of suitable wash material. It is a debatable point whether pupils should wear the full uniform of the association, but it is generally conceded that the hospital uniform should not be worn.

The selection of pupils to be sent out for public health training must, of course, remain in the hands of the superintendent of nurses of the hospital, unless the hospital is of such a size that it falls to the lot of every nurse. In this selection a superintendent may use various methods. If the elective system exists, the training may be given to such nurses as desire public health nursing experience. It may be given, as is an undergraduate head-nurseship, to those who seem particularly adapted to the work; or it may be indiscriminately given as best suits the convenience of the hospital. No nurse should be sent out early in her training. The third year is usually considered the most advantageous, because it is important that she should be thoroughly grounded in proper nursing methods before being required to make such modifications of technique as are often necessary in the district homes.

As a rule the hospital guarantees a nurse to the association and if illness occurs, even for a day, another nurse (usually one who has already had her district training) replaces the one who is ill. Occasionally difficulties arise, and sometimes a nurse sent out in all good faith fails so signally in this untried field of nursing as to be a real menace to the patients. If, after conscientious effort on the part of the association to teach such a nurse, this is found to be the case, the hospital should be willing to recall her, sending in her place another pupil. Affiliation is never, perhaps, perfectly easy, and district affiliation presents an added difficulty in that nurses continue to live at their hospitals, but there is no reason why such an arrangement should not work smoothly and well if both the hospital and the association recognise the respective difficulties of administration. The closer the co-operation between the two superintendents of nurses, the better the results are likely to be for the pupil. Individualisation is perhaps the keynote of success, and the

different side lights on character will be mutually helpful to both superintendents, if placed at each other's disposal. Of course no association will be able to give what it does not possess, no matter how great the desire, but if the methods employed are of the best, and if sympathy and a broad outlook on the work as a whole are the general policy, there is more unconscious absorption on the part of the pupil than is always realised.

The first question of importance for the association to consider in arranging the pupil's time and work is the method of supervision. This may be provided in two ways: one staff nurse may carry the entire responsibility of all the pupils; or each pupil may be placed under the supervisor or head nurse of the district in which she is to work. The former method has the advantage of providing a perhaps more uniform method of training; the latter method has the advantage of bringing the pupil more closely into the lives of the patients, because of the vital interest of the supervisor in the people of her own district. The important point in either method is that some one capable of teaching should be at all times sufficiently in touch with the pupil's work to be able to study her needs, and so give her the individualised instruction required.

As a general rule, which must admit of modification, a pupil should be taken to the homes of the patients for the first few days, after which she may begin to visit alone. She should, however, be accompanied at frequent intervals by her supervisor, or her cases visited on alternate days by her head nurse. While supervision is essential, resourcefulness can never be taught unless the pupil early begins to think for herself. We do not want to teach her to use newspapers instead of dressing towels, but we do want to teach her to use her mind in securing what will replace hospital equipment. She must also learn to observe things which have not existed in her hos-

pital experience. The detailed daily report given her head nurse or supervisor furnishes a valuable opportunity to teach this observation. Her early reports will probably deal exclusively with the patient's physical condition, but by judicious questioning she can be led to note and report other things; the needs of the household, the necessity for the intervention of other agencies, unhappiness caused by remediable conditions, etc., etc. Short, but carefully prepared written reports submitted at the end of the period of training will prove educative to both the pupil and those responsible for her supervision. The pupil will be led to a clearer view of her work and those supervising it will be able to gain from such reports an idea of whether the methods of teaching are producing desired results.

A long, difficult chronic case may often be given to advantage entirely into the hands of a pupil. The dependence of such cases on the nurse who cares for them does much to develop a sustained sympathy. Care should be taken, however, that the pupil's time is not too much taken up with chronic cases, always a temptation in busy districts. She will find the experience gained in preparing for the minor operations so common in district homes of great value, and she will learn, probably somewhat to her surprise, that a high standard of asepsis is quite possible in even a very poor home, provided the nurse has the resourcefulness to secure the essentials. The same may be said of the asepsis of the district obstetrical case, though here in the after-care, the nurse has the disadvantage of sharing the care of the patient with other people. In this very situation, however, lies one of the most important elements of her district training, for she will be successful just in so far as she is able to induce others to do in her absence the things that she considers necessary for her patient's comfort or well-being. This fact must be impressed upon her from the start, and stress must be laid

upon it, for nothing in her hospital training has developed this particular power.

At the close of the pupil's period of work with the association a written report should be sent the superintendent of her training school. The report may be divided into two parts, the marks in the first part affecting her general average throughout her entire hospital training, the marks in the second part being used merely as notes for future reference.

For example:

I

Quality of work.

Ability to carry responsibility.

Conduct.

II

Adaptability for public health work.

Power to gain confidence of family.

Interest in social work.

It would seem, perhaps, hardly fair that a nurse's marks for the three years of her training should be affected by inability to excel in these three latter ways, failure in which is due to personal bent rather than to lack of effort, and yet it is desirable to have information on these points on file with the nurse's record, for reference after graduation.

The question is sometimes asked whether small associations employing one nurse are justified in asking for a pupil nurse to assist her. The answer will depend on the attitude of the association. If only the work to be obtained from the pupil is considered, the answer must be an unqualified "no." If on the other hand, the obligation to the pupil is recognised, if the nurse employed by the association is capable of teaching, and if time is permitted her to do justice to her responsibility in this respect, the mere size of the association need be no hindrance

to an arrangement which may work advantageously for all concerned. In reckoning time, however, the pupil should not be considered as the equivalent of another graduate nurse. This is not because she herself is incapable of working at the actual bedside with as much rapidity as the graduate, but because her training takes such a heavy toll of time from the nurse who supervises her work, and also because her cases must be selected with a view to what she is to gain from them, rather than from the point of view of the saving of time.

There is one great gain which comes to any association with the pupil nurse, and that is the spirit and inspiration which is brought in by the constant influx of fresh eager young nurses, full of a probing interest and a desire to learn. The necessity of teaching keeps the staff nurses from falling into a rut, and acts as a daily stimulus to good work. In addition, the staff nurses will find it of great advantage to keep in touch with the latest hospital methods, many of which are likely to have been changed since their own graduation.

As was stated at the beginning of the chapter the writer feels deeply the futility of attempting at this moment to speak with authority on the subject of undergraduate training for public health nursing. Many of the best minds in the field of nursing education are being brought to bear on the problem, and it is to be hoped that within a few years a wise solution will have been reached.

The present chapter makes no effort to point a way. In it we have merely tried to place a few warning signs across the roads which lead to the exploitation of the pupil for the work she can do, to claim for her systematic educative supervision, and to assert the fact that much good may come to her from even a short time properly spent in home district nursing.

CHAPTER VIII

METHODS OF ORGANISATION AND ADMINISTRATION

LOCAL conditions rightly have an important influence on the form of organisation most desirable for each city or town, nevertheless all visiting nurse associations may gain something from the study of methods successfully employed in other places, and not infrequently these same methods in modified form may be transplanted to advantage.

Because this is felt to be true, this chapter will contain a short account of methods of organisation and administration that seem to be working well in five different visiting nurse associations and in one nursing settlement. These particular organisations have been selected because each represents a type, and because in each some one form or aspect of the work has been peculiarly emphasised.

The Henry Street Settlement in New York embodies the settlement idea and emphasises the close relationship between the care of the sick and all other community problems. The Boston Association was the first to combine the work of staff and post-graduate student nurses. In Cleveland the problem of affiliation of agencies has been worked out through a central committee, and in addition hourly nursing is undertaken by the association. Chicago represents well-organised work in a very large city, and shows the successful development of industrial nursing. Dayton is trying the experiment of a single nurse in a small district caring for all types of cases, and the Dayton Association is also interesting in that the work is supported by three different agencies. In Providence

the ward method of administering districts is used, with different special services maintained under one management. In Providence, as in Cleveland, hourly nursing is undertaken.¹

HENRY STREET SETTLEMENT NEW YORK CITY

All nursing matters are controlled by a committee of eight, of whom seven are nurses and the eighth a statistician. On this committee are the Head Resident, Superintendent of Nurses, Associate Superintendent, Instructor, and a former Superintendent.

Finances are administered by the Board of Directors of the Settlement, of which two of the Committee are members. The Head Resident is also President of the Board of Directors and Chairman of the Nursing Committee.

Funds for the support of the nursing service are derived from individuals, who pay whole or part salaries, from payments by the Metropolitan Life Insurance Company for the care of its policy holders, and from fees from patients. In 1915 about a quarter of the total number of patients were nursed free of charge.

ADMINISTRATION OF NURSING SERVICE

The nursing staff consists of a superintendent of nurses, and an associate superintendent, two teachers, seven supervisors and about one hundred field nurses. The two teachers, who are also supervisors, instruct all new nurses and follow their work with special care during the first few months.

Records and statistics are handled in the clerical office, the force consisting of a statistician, three recording nurses and three clerks. Every effort is made to record and collate facts regarding the cases in such a way as to be of service in shaping policies in various lines of social and medical work carried on by the City or by private agencies.

The work is divided into three departments:—general,

¹ The information contained in this chapter has been gathered in 1916.

obstetrical and contagious nursing, each with its own staff. Calls are received at the main office at any time and distributed to the district offices between the hours of 8 and 9 A. M. and 1 and 2 P. M. There are twelve centres at which the nurses report at 8:30 A. M. for new calls and conference with their supervisors. They leave at 9 for their districts, where they work until 5 P. M. Most of the nurses report at their centres again at noon unless distances are too great, in which case they telephone. Written reports of the day's work are mailed each night to the main office, a carbon copy being given the next morning to the supervisor. Each centre has a head nurse, who in addition to her district work is responsible for supplies, and in the absence of the supervisor distributes the work to the other nurses.

The district offices are for the most part in quarters assigned by friendly co-operating agencies, settlements, relief agencies, and, in one instance, a public school.

A room at the main house of the Settlement is fitted up for the treatment of minor surgical cases, the treatment being prescribed by private physicians or by the dispensary doctors. In four other settlement centres similar provision is made. These dressing rooms save the nurses many home visits and form important centres for social service and neighbourhood work.

A first visit is made on every case reported, but nurses do not continue to care for the case unless a physician is in attendance, or has assumed the responsibility. A fee is charged covering the cost price of the visit. Patients unable to pay this amount make payment according to their means. Free service is given to those unable to pay anything. For patients who are in a critical condition, the Settlement sometimes furnishes a night nurse for a few nights. Private duty nurses are called from a registry for this service, the Settlement assuming responsibility for the expense and encouraging the family of the patient to pay as large a portion of it as possible.

Contagious work is carried on by a staff of nurses who give their time exclusively to the bedside care of patients suffering from measles, diphtheria, and scarlet fever. The num-

ber of nurses on this service varies with the need, and as contagious work is light during the summer months, the contagious nurses are available for vacation substituting.

The City maintains a staff of nurses for advisory work in connection with tuberculosis, but bed-ridden cases are referred to Henry Street nurses. Full responsibility for patient and family is transferred to the Settlement nurse, and at the termination of the case, whether by death or removal to hospital, the special form of record kept by the nurse is returned to the Department of Health and incorporated with its records.

The Obstetrical Staff has recently changed its method of procedure. Instead of dismissing mother and baby, ten or twelve days after delivery, the baby is visited once a week until it is one month old, unless before that time it has been registered at a milk station, the object being to tide the babies over the month during which mortality is greatest, and during which it is also the most difficult for the mother to go out to attend baby clinics. Another purpose for this procedure is to ascertain how many mothers are returning to work before the baby is a month old and for what reasons.

One nurse is assigned for duty for an hour each day at the Children's Court to examine cases under the care of the Society for Prevention of Cruelty to Children.

A nurse is also assigned for full time work to the Joint Board of Sanitary Control for the monthly visitation of factories to give instruction in the use of the first aid kit required by the state law, to give talks to the operators on matters of hygiene, and to follow up individual cases of illness. The Settlement has likewise made an arrangement with the Mutual Benefit Association of the National Cloak and Suit Company to visit all employ  s reported as sick.

During the summer a country house is available for the care of mothers with small babies who are convalescent from recent illness. Another farm house is under the management of the nurse in one of the Italian districts for convalescents of that nationality. One year-round convalescent home, accommodating ten patients, is a great resource in caring for ex-patients who must regain their strength after long ill-

nesses, for others who need good air and food in order to ward off threatened breakdowns, and for staff nurses in need of a little rest or change.

An effort is made to render membership on the regular staff an educational opportunity for the nurses. During the winter, staff meetings are held twice a month and addresses are given by experts in various fields allied to visiting nursing. During the summer, excursions are arranged to the various institutions to which patients may be referred. Nurses on the staff are allowed time as far as is compatible with the needs of the service, to take approved courses at Teachers' College and the School of Philanthropy.

Besides giving such training to many nurses who leave New York to carry on public health activities elsewhere, the Settlement co-operates with Teachers' College, the Department of Health, the School of Philanthropy and the Charity Organisation in giving an eight months' course of lectures and practical experience in Public Health Nursing. Nurses taking this course spend two months of their time in district work at the Settlement.

In addition to its nursing service the Henry Street Settlement carries on all the activities usual to Settlement work, as well as some peculiar to itself. Men and women representing a vast number of interests come to it as visitors, and a goodly number make their home under its hospitable roof. While few of the nursing staff actually live at the Settlement, connection with its varied interests serves to promote in the minds of all the nurses an understanding of social problems other than those of sickness. Over twenty years of work for individual and civic betterment have brought to the Henry Street Settlement the love and confidence of the neighbourhood and an assured position in the life of the City. These things help the nursing staff to acquire an unusual sensitiveness to the needs of the people, and the result has been a number of pioneer enterprises, as, for example, the inauguration of school nursing, which have blazed the way for like efforts in other cities.

THE BOSTON INSTRUCTIVE DISTRICT NURSING ASSOCIATION, BOSTON, MASSACHUSETTS

MEMBERSHIP

Any person may become a member of the Association by a two-thirds vote of those present at any meeting of the Corporation. Membership is also automatically conferred on those who have at any time served upon the Board of Managers, or who have contributed to the Association the sum of \$100.00 or more, or who for the time being serve upon the Advisory Board or Finance Committee.

BOARD OF MANAGERS

The work of the Association is governed by a Board of Managers consisting of a President, two Vice-Presidents, a Secretary, and not less than eleven nor more than twenty-three managers. The Board is made up of men and women. Board meetings are held monthly. In the four summer months the Board does not meet, but the Executive Committee meets throughout the year.

The chief executive officer is a Director, who has power to administer the affairs of the Association and to make decisions not involving unusual expense. The Director reports in full to the Executive Committee and to the Board of Managers, and is an ex-officio member of all sub-committees.

STANDING COMMITTEES

The Executive Committee is composed of the President as Chairman, the Secretary, and seven other members of the Board of Managers, and holds regular monthly meetings just previous to the Board meeting. This Committee discusses all matters relating to the work of the Association and makes recommendations to the Board. It has full power to act in all affairs of the Association whenever immediate action is required.

The Finance Committee is composed of the Treasurer and two other men nominated by the Board, and acts as an advisory committee on questions of finance.

The Committee on Nurses is composed of three members of the Board and meets every two weeks. It acts as an ad-

visory committee to the Director in all matters pertaining to nurses.

The Committee on Education is composed of three members of the Board, and meets as occasion requires. It acts upon all matters pertaining to the Educational Department, and is an advisory board to the Head of that Department.

The House and Supply Committee is composed of four members of the Board and the Staff Superintendent. It meets monthly. It has general oversight of the Central House and makes periodic inspections of it. It confers with the Director on all questions of policy, and has power to act on her suggestions pertaining to the house and supplies, except on questions involving unusual expense which are referred to the Board. It buys all nursing supplies, and approves all bills.

The Committee on Bills is composed of two members of the Board of Managers. It approves all bills for payment by Treasurer that have been previously approved by the Director.

The Legislative Committee is composed of three members of the Board of Managers. Its purpose is to aid in promoting and obtaining all desirable public health legislation.

The Ways and Means Committee is composed of the President, as Chairman, and seven other members of the Board of Managers, and meets monthly. Its function is to consider ways and means of raising the funds necessary to carry on the work of the Association.

The Volunteers are a group of young women who meet weekly to make supplies and to do clerical work. From time to time members of the Board of Managers have been appointed from this group.

The Association is a private corporation, and its work is supported financially by income from endowment funds, contributions from private individuals, fees from patients, and payments from the Metropolitan Life Insurance Company for nursing care of their Industrial Policy holders.

ADMINISTRATION OF NURSING SERVICE

The Nursing force consists of the Director, Head of Department of Education, Staff Superintendent, and a practical

instructor of the post-graduates and under-graduates, together with fifty-six salaried nurses and a varying number of post-graduate and under-graduate students in its course in public health nursing.

The city is subdivided into nine districts in each of which there is a sub-station with a supervisor in charge, and a sufficient number of nurses to do the work of the district. One district is given over entirely to the students for their practical instruction in public health nursing.

Each nurse reports at the station to which she is assigned at 8:30 A. M., at noon and at 5 P. M. to receive her calls, to discuss her cases with the supervisor and to do her clerical work. The clerical work consists in writing the medical and social history cards for each patient under her care, and in making up her daily report sheet of patients visited, with the time spent and service rendered to each. The Supervisor mails these daily reports to the Registrar at the main office with a slip giving the total work of the station.

The Registrar keeps a daily record by stations of the number of patients admitted, visited, and discharged. She keeps a card catalogue of the patients, classified by name and by street address, files numerically the histories of all discharged cases, and makes up a monthly statistical sheet of all discharged cases in accordance with the National Classification of Diseases, with age, nationality and results.

Calls for nurses are accepted from any source, and are received at the Central Office at all hours, and at the branch stations during the office hours of the supervisors. While no case is continued where a doctor is not in attendance, a single investigating visit is always made. A fee is charged covering the cost price of each visit. Patients unable to pay this amount make payment according to their means — free service is given to those unable to pay anything. The Association does not nurse patients suffering with scarlet fever, diphtheria or small-pox. It does not do tuberculosis nursing, school nursing, or (except in its care of prenatal cases) infant welfare work — this is done by municipal nurses and by the Baby Hygiene Association.

Under supervision of the Association one staff nurse is

doing factory welfare work, and one follow-up work in connection with day nurseries.

Under the direction of the Association is a Visiting Housekeeper, who visits homes in need of practical advice on house-keeping. She teaches cooking, marketing, cleaning, plain sewing, planning of the family budget, and the simple rules of health, hygiene and home sanitation.

The Director holds a weekly conference attended by all the nurses and students. At this meeting statistics of the work are given, and matters of special or general interest are discussed. The first meeting each month is attended also by the nurses of the Baby Hygiene Association, and is usually addressed by a speaker engaged in some line of work of special interest to public health nurses.

The Director meets the supervisors weekly for a general discussion of the work of the stations and the problems of the supervisors.

Case committees meet in the various districts to discuss the social problems which the nurses bring before them for advice. These committees may be made up of members of the Board of Managers and of such local workers as the district secretary of the Associated Charities, a doctor or priest, a settlement house worker, an agent of the conference of St. Vincent de Paul, and the supervisor.

A quarterly meeting of the Massachusetts Club for Public Health Nurses is held in Boston for the purpose of bringing into more intimate contact all the nurses doing public health work in the City and in the smaller outlying towns and cities. At these meetings supper is served, after which there is a short talk on some subject of general interest. A social evening follows.

The educational department of the Association offers two courses to graduate nurses desiring a preparation in public health nursing. The eight months' course offered is in connection with Simmons College and the School for Social Workers.¹ The work at Simmons College includes courses in

¹ In 1916 a Department of Public Health Nursing was created at Simmons offering a course covering one academic year in connection

sanitary science and public health, applied bacteriology, municipal, rural and industrial sanitation, preventive medicine, social legislation, principles of education and household economics. At the School for Social Workers lectures and conferences are given throughout the year on the principles and methods of social service in their application to present day problems, with related and supervised practical work. Practical nursing experience is also arranged and supervised by the Instructive District Nursing Association. The four months' course, under the direct management of the Association, is designed to give a basis for a variety of social work in which nurses are in demand. Instruction is given in the procedures of district and visiting nursing in all branches. The preventive and educational aspects of the work are taken up and practical experience given in the principles and methods of organised relief through field work, lectures and class discussion.

A special district is set apart for the practical work of these students, which is under the supervision of a special instructor.

A fee is charged for both courses, but scholarships are available.

In addition to the graduate nurses who take this course, arrangements have been made with certain hospitals whereby pupil nurses in their senior year may have two months' practical experience in visiting nursing under the supervision of the Association, and, if satisfactory, may return after graduation for the two remaining months, receiving at the end a diploma for the full course; or a selected pupil may in her senior year receive the entire four months of training, and at graduation be awarded the diploma of the Association at the same time with that of her school. Under both conditions the pupil nurses have the advantage of all classes and conferences open to the post-graduate students.

For both courses there is affiliation with a large number of other agencies which give to the nurses experience of observation in the different lines of work.

with the Instructive District Nursing Association and the School for Social Workers.

The Association owns a house which is used as headquarters for the work, and at which a house-mother, one of two heads of departments and some of the post-graduate students, holding scholarships, live. Here all meetings of the Association are held, as are also the classes and lectures of the Educational Department. A reference library is maintained by the Educational department.

The office of the Registrar is at this Central House, and all the records of the Association are kept there.

THE VISITING NURSE ASSOCIATION OF CLEVELAND, OHIO

MEMBERSHIP

The membership of the Association consists of such persons as contribute to its purposes either by personal work or subscription to its funds. There are honorary members who maintain under the Association a visiting nurse, and associate members who contribute annually to the work of the Association. All members are entitled to a vote and otherwise take part in the proceedings of the Association.

BOARD OF TRUSTEES

The management of the Association is vested in a Board of Trustees which consists of not less than thirty or more than forty men and women. The Board meets monthly.

The Executive Board meets monthly, previous to the meetings of the Board of Trustees, and transacts the regular routine business of the Association, and also such special business as may be assigned to it.¹

The Committee on Nurses consists of at least five members of the Board of Trustees. Its chairman is a member of the Executive Board.

The Committee on Supplies consists of at least three members of the Board of Trustees, together with members of an auxiliary club. Its chairman is a member of the Executive Board.

The Committee on Printing and Publication consists of at

¹ The experiment has been tried of having joint meetings of the Executive Committee and the Board of Trustees with a view to strengthening the interest of the Board.

least three members of the Board of Trustees. The Committee on Records consists of three members of the Board of Trustees. The chairman is a member of the Executive Board.

The Committee on Chronic and Problem Cases consists of at least three members of the Board of Trustees together with such auxiliary members as may be helpful. This Committee acts as guardian to a trust fund.

The Committee on Ways and Means consists of three members of the Board of Trustees and at least three men of business attainments in the City of Cleveland. This Committee assists in devising ways and means of raising funds.

The Committee on Contracts consists of at least four members of the Board of Trustees. This Committee is responsible for the drawing up of all contracts with other organisations.

The Committee on Investments consists of five men of known business attainments in the City of Cleveland.

The Committee on Metropolitan Work consists of five, four of whom are members of the Board of Trustees, and exists for the purpose of dealing with the Metropolitan Life Insurance Company in regard to nursing service performed for them.

The Committee on Training Nurses for Social Work consists of fourteen members of the Board of Trustees.

The Neighbourhood Nursing Committee consists of four trustees and the superintendent of nurses. The duties of this Committee are the organisation and conduct of the self-supporting nursing service, later described in detail.

The Central Committee is composed of representatives from the various agencies doing public health nursing in Cleveland. This Committee will be described below.

The income of the Association is derived from three sources: from gifts or donations, from interest on endowments, and from payment for services rendered.

ADMINISTRATION OF NURSING SERVICE

The staff consists of forty nurses (exclusive of three hospital pupils) working in ten districts, six factories, a crip-

pled children's home, two maternity dispensaries, and the social service department of Lakeside Hospital.

The Work is supervised by three district supervisors in addition to the Superintendent of nurses and her assistant. Weekly staff meetings and weekly supervisors' meetings are held, also occasional meetings for all public health nurses of the City.

Two neighbourhood centres have been established fully equipped with filing cases, records and a full time stenographer. From five to seven nurses under the charge of a supervisor make use of each centre. A teaching centre is also in process of organisation in connection with the course for public health nursing offered by the School of Applied Social Science, Western Reserve University.

Calls are received from all sources, but a doctor must be in attendance if care is to be continued. A fee is charged covering the cost price of each visit. Patients unable to pay this amount make payment according to their means. Free service is given to those unable to pay anything.

Tuberculosis, child hygiene and infant welfare work, school and contagious nursing are not done by the Association, as these fields are covered by other private agencies or by the municipality.

The special course in public health nursing which has been maintained by the Visiting Nurse Association in co-operation with the Department of Sociology of Western Reserve University, the Associated Charities, the Anti-Tuberculosis League, the Babies' Dispensary and Hospital, and the Department of Medical Inspection of the Board of Education has recently become a constituent part of the Division of Health Administration in the School of Applied Sciences of Western Reserve University. In addition to the usual courses of study, practical training is offered in the field of general visiting nursing, child hygiene, tuberculosis and school nursing and organised charity. A certain number of scholarships are available.

The Association has recently (1915) extended its nursing service on the visit basis to all desiring nursing care in the home and not requiring a resident nurse, hoping in this way

to meet the need of people of moderate means. During the day calls are taken by the regular nurses of the district. Night and emergency service is provided, but nurses for it are called from the Central Registry of the Graduate Nurses' Association, a nurse being sent as a visiting nurse to meet these needs until such time as the night work warrants the regular employment by the Association of a night nurse or nurses. Obstetrical cases are visited before and after confinement and the nurse is also present at the time of delivery. Charges for this service are based upon its actual cost and are as follows:— 75 cents per visit not exceeding one hour, and an additional charge of 50 cents for the second hour or part thereof. Preparations for and services during minor operations and confinements \$5.00 per case; subsequent visits at regular rates. After 6 P. M. a charge of \$1.00 is made for the first hour. The nurse collects the fees.

To secure unity the Association has for some years undertaken to engage all the nurses required for public health nursing in Cleveland, giving them as far as possible some experience in social nursing before placing them with other organisations. As the number of nurses required increased, this burden became greater and greater. Demands came not only from private organisations, but from the municipality as well. What had been started as a simple and convenient arrangement owing to growth became for many reasons difficult of administration. It was still felt, however, that the common standard, and the common uniform, thus provided meant too much to be given up.

In 1912, therefore, it was decided to form a Central Committee on Public Health Nursing to deal with the general questions common to all. The membership of the Committee is composed of two representatives from each organisation doing public health nursing in any of its forms, one representative being the supervising nurse, or, if there be none, the medical director; the other a lay member with a chairman and vice-chairman appointed from the Visiting Nurse Association's Board of Trustees.

All applications for positions are made to the Central Committee, and as soon as accepted the nurse is assigned to the

staff having the earliest vacancy. After three months of probation, if satisfactory to the superintendent of the organisation to which she has been assigned, she becomes a regular member of the staff. A nurse may, however, apply for work on a particular staff, in which case her request is complied with as soon as possible, even though an earlier vacancy may thus be left unfilled. All nurses continue to wear a common uniform and there is a common standard for hours of work and salaries.

The questions considered by the Central Committee are:

1. Standard of requirement for admission to the staff of public health nurses.
2. Standard salaries. Salaries during vacations and illness.
3. Length of vacations.
4. Group insurance for nurses.
5. General rules for all public health nurses.
6. Uniforms.
7. Applications for nurses.
8. Applications from nurses.
9. Appointments.
10. Vacation substitutes.
11. Resignations.

There are two sub-committees: a uniform committee which takes charge of the uniforms, ordering at wholesale prices and supplying the organisations on requisition; the other, a committee on eligibility. The latter is composed of the chairman of the Central Committee and the superintendents of each staff of nurses. This committee meets weekly and reports its action for ratification at the monthly meetings of the Central Committee.

It is felt that the establishment of the Central Committee has been of great value to the public health nursing work of the city. Uniform standards have been set and maintained, co-operation has been secured, over-lapping and friction avoided, and the city served by a body of nurses wearing a common uniform and measuring up to a common standard of efficiency.

CHICAGO VISITING NURSE ASSOCIATION
CHICAGO, ILLINOIS

MEMBERSHIP

Any person by annual payment of five dollars or more becomes a member of the Association.

BOARD OF MANAGERS

The work of the Association is governed by a Board of forty-two women. There is in addition an advisory committee of nine men, who may be called upon if necessary. The board meets monthly throughout the year.

STANDING COMMITTEES

The Committee on Finance plans ways and means of raising money, apportioning to each manager the amount to be raised by her.

The Nurses' Committee meets monthly, and receives reports from the supervisors of the work of their territories, and also from the Superintendent of the work as a whole. All matters concerning the nurses are considered by this committee before being brought to the Board of Managers.

The Committee on Domestic Instruction supervises the work of a Domestic Educator and also interests itself in courses of instruction for the nurses on the subjects of domestic economy, dietetics and cooking, with special reference to the expenditures in workingmen's homes.

The Office Committee considers any increased expenditure in this department, or any changes in the office staff.

The Savings Committee stands ready to advise the nurses in regard to the investment of their savings. The Association holds back seven per cent of each nurse's monthly salary, placing it for her in a savings bank. The bank books are kept in the office of the Association, open to inspection, and accrued amounts are given to the owner when she leaves the Association, or at the discretion of the Savings Committee. This method of encouraging saving is liked by the Chicago nurses.

The Committee on Publicity is responsible for all public speaking, collects data when necessary, and approaches the

newspapers in regard to reports of the work, notices or space for "stories."

The Committee on Co-operation concerns itself with the relation of the Association to other agencies.

The Uniform Committee is explained by its name.

The Auxiliary Committee is composed of a group of young girls who make supplies, collect magazines or books for the patients and otherwise help the work of the Association.

The Sub-station Committee consists of twenty members, two members being assigned to each sub-station. The members visit the sub-station once or twice each month to confer with the nurses. They also provide incidental supplies (old linen, toys, dishes, etc.). The Committee as a whole meets every two months.

The work is financed by endowment, by the support of memorial nurses, by members' dues, by salaries paid by the Metropolitan Life Insurance Company or Industrial concerns, by fees from patients, and by general and special subscriptions. The general subscriptions are raised by the Board, a certain amount being apportioned to each member as her responsibility.

ADMINISTRATION OF NURSING SERVICE

The nursing force consists of a Superintendent, six supervisors, one of whom acts as registrar in the main office, and another as teaching supervisor, a domestic educator,¹ and about seventy-five staff nurses. The city is districted, each district being cared for by one nurse. The nurses receive their daily calls at their sub-stations at noon, and at their homes at night. All calls from whatever source are answered, but visits are not continued unless a doctor is in attendance. A fee is charged covering the cost price of each visit. Patients unable to pay this amount make payment according to their means. Free service is given to those unable to pay anything.

Tuberculosis, school nursing, and the care of well babies are undertaken by the municipality and a private agency. All other types of cases are cared for by the Association.

Nine nurses are supported by industrial firms. They are

¹ Temporarily given up.

engaged by the superintendent of nurses and their names are on the pay roll of the Association, a monthly bill being sent to the firms for their services. They also wear the uniform of the Association.

Supervision of these nurses is provided by means of weekly conferences, monthly statistical reports and occasional visits from the superintendent of nurses. The Superintendent keeps in touch with representatives of the firms. The work of the industrial nurse varies. Some take charge of accident cases only. One spends one-half time at the plant, doing dispensary work. Others after two hours in the factory each noon spend the rest of the day in home visiting. In most instances the family, as well as the employé himself, is cared for. There is little or no difference between the work of the industrial nurse and that of the general visiting nurse, except that the former confines her efforts strictly to the families of the employés of the firm, and her headquarters are at the firm, instead of at a sub-station.

Such cases as are necessarily given up by the industrial nurse are cared for by the other visiting nurses, and the usual charge for their services made.

It is generally conceded that the industrial nurse does much to increase the efficiency of the employé, and to bring about a better understanding between the firm and those employed by it. It is also generally conceded that by engaging nurses who are members of the staff of the Visiting Nurse Association the public health nursing of the city is strengthened, standards are maintained, over-lapping is avoided, and co-operation is assured.

DAYTON VISITING NURSE ASSOCIATION DAYTON, OHIO

MEMBERSHIP

Any person by payment of the annual dues of one dollar becomes a member of the Association.

BOARD OF MANAGERS

The Association is governed by a Board of sixteen managers, all of whom are women. Meetings of the Board are

held monthly. All members of committees who are not members of the Board attend monthly meetings but do not vote.

STANDING COMMITTEES

The Nurses' Committee is composed of seven members, and meets monthly to consider all matters pertaining to the nurses.

The Ways and Means Committee is composed of six members, who meet on call to consider the financial situation.

The Supplies Committee is composed of seven members and takes charge of all supplies. This Committee works under the direction of a chairman, without meeting.

The Farm Committee is composed of five members, and has charge of the fresh air work of the Association. A farm is maintained and run by a group of one hundred young women which is called the Fresh Air Branch of the Visiting Nurse Association. The farm is open during the ten summer weeks for city children, and averages about one hundred and fifty children each summer. The property is a loan to the Association which pays for all permanent improvements, while the Fresh Air Branch raises the money annually for the running expenses.

ADMINISTRATION OF NURSING SERVICE

To understand the present situation in Dayton a brief glance at the development of its nursing service will be necessary.

Previous to the fall of 1913 there were two organisations doing district nursing; one, the Visiting Nurse Association, then known as the Flower and Fruit Mission, a philanthropic organisation doing general visiting nursing and infant welfare work with a force of four nurses and a visiting housekeeper; the other, the Tuberculosis Society, also a philanthropic organisation, employing one nurse to instruct tuberculous patients. In the fall of 1913 a Superintendent was added to the staff of the first-named organisation. Also in the fall of 1913, due to an epidemic of diphtheria, the Health Department of the city employed four nurses for quarantine work. After the epidemic these nurses were retained for

quarantine instructive nursing and sanitary inspection. There were, therefore, four visiting nurses, one tuberculosis nurse, and four quarantine nurses working independently of each other and with little co-operation.

As this arrangement was obviously undesirable it was thought best to unite the three sets of nurses in a single staff, with one headquarters and under a single direction.

The process of re-organisation took the following course:

The Visiting Nurses' Association and the Tuberculosis Society moved into the offices of the Department of Welfare of the City, of which the Health Department is a division. This brought all the nurses into a common office. The Superintendent of the Visiting Nurses' Association was made Superintendent of the whole staff. The two private philanthropies, the Visiting Nurses' Association and Tuberculosis Society, retained their autonomy and their authority over their respective nurses and services, each organisation paying its own expenses.

The Tuberculosis Society has a board of four men and three women meeting monthly. This Society carries on an educational campaign as well as a nursing service.

The commission-city-manager plan of Dayton's government has five departments; Law, Finance, Service, Safety, and Welfare. The Department of Welfare has six divisions including the Division of Health under the Commissioner of Health. The Division of Health has five sub-divisions, one being the Bureau of Medical Service, which includes the district doctors and nurses. The Nursing Service for the Division of Health is, as we have said, under the Superintendent of nurses, employed by the Visiting Nurses' Association, who reports to the Commissioner of Health, and receives all orders covering quarantine, sanitation and clinics from him.

The Tuberculosis Society pays the salary of one nurse, her carfare, and purchases her uniforms, also tents, sputum cups and other appliances required by tubercular patients.

The Division of Health pays the salaries and carfare of four nurses, furnishes the headquarters, light and telephone and janitor service, purchases the drugs, and provides all records, stationery, files, etc., needed to carry on its nursing work.

The Visiting Nurses' Association pays the salaries of the superintendent, five nurses and the office secretary, furnishes carfare for its nurses, provides the uniforms for its own and the Division of Health nurses, provides the supplies needed in giving nursing care, the bags and all other necessities incident to the running of any general visiting nurse association. The complete staff numbers one superintendent, ten nurses, a student nurse from the hospital and one visiting housekeeper.

After a brief trial it was decided to re-district the city, making each district so small that a single nurse could care for all types of cases, thereby doing away with specialisation. A fee is charged covering the cost price of each visit. Patients unable to pay this amount make payment according to their means. Free service is given to those unable to pay anything.

The nurses report at the office at eight o'clock in the morning, spending one-half hour in clerical work, receiving new calls, supplying bags, receiving instructions, etc. They reach their districts by 9 o'clock or 9:30. They call the office for new calls between 12:00 and 1:00 and again between 4:00 and 5:00. They go directly home from their districts at 5 o'clock. All the nurses are sworn in as sanitary police in order that quarantine may be rigidly enforced.

The present situation in Dayton has existed for too short a period (but little over three years at the time of writing) to make it safe to draw too definite conclusions. It is felt, however, that the work of the Visiting Nurse Association has increased both in volume and effectiveness, that the reach of the Tuberculosis Society has been materially broadened, and that the municipal nursing service has gained in strength through expert supervision. It is also felt that the generalisation of the work under a single nurse in a small district is sufficiently successful to justify every reason for its adoption.

Miss Elizabeth Fox, who as former Superintendent of nurses had charge of the work at the time of its reconstruction, makes the following recommendations:

First. Such a plan should only be adopted under favourable political conditions.

Second. There must be a large enough staff to meet the increased demands.

Third. There must be adequate supervision for so varied and complete an undertaking.

PROVIDENCE DISTRICT NURSING ASSOCIATION, PROVIDENCE, R. I.

MEMBERSHIP

Any person may be elected to membership by the Board of Managers at any meeting provided that said person shall have been nominated at the previous meeting of the Board.

BOARD OF MANAGERS

The work of the Association is governed by a Board of Managers, consisting of a President, three Vice-Presidents, Secretary, Assistant Secretary, Treasurer, Assistant Treasurer, and twenty-two Directors. The Board is made up of men and women, elected at the annual meeting of the Corporation.

STANDING COMMITTEES

The Advisory Committee consists of such persons as the President may appoint. The Committee meets upon the call of the President or Board of Managers.

The Finance Committee consists of the Treasurer and two other members, and acts as an advisory committee on matters of finance.

The Nurses' Committee consists of not more than twelve members, who meet monthly and supervise the work of the nurses. All matters pertaining to the nurses are considered by this committee before being brought to the Board of Managers.

The Committee on home dietetics consists of twelve members, meets monthly, and supervises the work of the visiting dietitian.

A Donation Day Committee is annually appointed by the President.

The Association is a private corporation supported by income from endowment funds, by annual donations and contributions, by fees from patients, and by payments from the

Metropolitan Life Insurance Company for the care of its industrial policy-holders. An annual subsidy is also received from the city.

ADMINISTRATION OF NURSING SERVICE

The nursing force consists of a superintendent, an assistant superintendent, twenty-seven staff nurses, seven of whom are head nurses, and seven pupil nurses, making a total of thirty-six nurses. In addition there is a visiting dietitian, who is not a nurse. The office work is carried on by one recorder, and an assistant, both of whom are stenographers. The seven pupils are sent out from four hospitals for periods of six weeks, and two months, as part of their training. During this time they live at their hospitals and return to them for all classes and lectures.

The work of the Association is divided into five services: the general service, which cares for all cases of sickness needing bedside care; two advisory services, one for tuberculosis, and one for children; a dietitian's service; and an hourly nursing service. The cases of the hourly nursing service, though recorded separately for statistical purposes, are cared for by the nurses of the general service. There is one industrial nurse.

For the general work the city is divided into large districts, each district in charge of a head nurse, with an assistant head nurse, and as many floating nurses as the district at the time requires.

The head nurse and her assistant correspond to the head and senior nurses of a hospital ward, the head nurse being held responsible for all the affairs of her district, for records and reports, for the health of her nurses, for the harmonious co-operation between doctors and other agencies, for the training of her pupil nurse, for economy in the use of supplies, as well as for all the purely technical details of the nursing work. The head nurses also give nursing care in their districts.

Each advisory service is in charge of a head nurse who is responsible for the work of all nurses under her, and also for the general development of her special service.

The visiting dietitian teaches cooking, planning of the

family budget, marketing and the fundamental principles of good housekeeping. Under the supervision of physicians, she carries cases requiring special diets. She also conducts classes and gives talks on housekeeping and dietary subjects.

Calls are received from all sources but visits are not continued unless a doctor is in attendance. A fee is charged covering the cost of each visit. Patients unable to pay this amount make payment according to their means. Free service is given to those unable to pay anything.

All nurses meet daily at the office of the Association at 8 A. M. Tables are provided for each district. The head nurse receives from her nurses a detailed account of the work of the previous day, assigns new work and aided by her assistant does the necessary clerical work of the day. In case of the illness or absence of a head nurse, her assistant automatically takes charge of the district. All nurses report to their head nurses by telephone at noon, while she in turn reports to the office, either personally or by telephone.

Pupil nurses visit with the head nurse or her assistant for the first few days, after which they visit alone under careful supervision, their training being considered an important part of the duties of the head nurse. Hats, coats, carfare and supplies are furnished the pupils by the Association.

The working hours of the nurses are from 8 A. M. to 5 P. M., with one hour for luncheon. One free afternoon is given each week, the choice of the day being as far as possible left with the nurse. The tuberculosis nurses have one free day a month in addition. The pupils and one staff nurse are on duty each Sunday morning, Sunday duty being undertaken in rotation by the staff nurses.

The Association has very recently (1916) inaugurated an hourly nursing service by which nurses are furnished on a visit basis at reasonable prices to all those not requiring a resident nurse or unable to afford one. The hourly cases are taken by the regular nurses of the district, the difference between hourly and other cases being that an hourly nurse may be had at the time the patient desires her and kept for as long as required. As the service pays for itself additional nurses are added when necessary, the assistance being fur-

nished to the district. Night and evening calls are taken by staff nurses volunteering for such work, but in no case are more than eight hours of work in the twenty-four done by any nurse. Charges for this hourly service between the hours of 8 A. M. and 5 P. M. are 75 cents for the first hour, and 50 cents for each consecutive additional hour. From 5 P. M. to 8 A. M. the charge is \$1.00 for the first hour, and 50 cents for each additional hour. Preparation for and services during minor operations and confinements are charged for at the rate of \$5.00 per case. Subsequent visits at the regular rate. The additional charge for night and evening care tends to keep the work within the usual working hours of the nurses. Consultations with committees from the State Graduate Nurses' Association, the Central Directory for Nurses, and the Young Women's Christian Association, were held before inaugurating the hourly nursing service. This conference felt that such a service as described would not work a hardship upon the private nurses of the city.

Weekly meetings of the nurses are held from 8:30 to 9:30 every Tuesday morning, and are attended by the municipal nurses, the only other public health nurses of the city. School nursing, the following-up of mid-wife cases and the inspection of licensed infant boarding houses are done by the municipal nurses. Monthly meetings of the Rhode Island Visiting Nurses Club are held in the rooms of the Association, and attended by all the public health nurses of the state.

To summarise the foregoing:—All the organisations except Henry Street have a large membership; conferred in Boston by vote of the Board, or automatically on certain officers or on account of large financial support, in Cleveland in recognition of either personal service or financial support, in Chicago and Dayton by payment of dues, and in Providence by vote of the Board.

All the organisations except Henry Street are governed by directorates. In Boston, Chicago and Dayton, the directorates are composed entirely of women, in Cleveland and Providence of both men and women.

Henry Street is unique in its form of government, all its nursing affairs being in the hands of a committee of eight all

but one of whom are nurses. This committee partakes rather of the nature of a council of workers than of an outside governing body.

Chicago and Providence have in addition to their directorates, advisory committees.

Boston and Cleveland have executive committees, though in Cleveland the meetings of the committee are being merged in those of the board.

Twenty-six different types of standing committees exist in the six organisations, Cleveland having twelve, Chicago eleven, Boston nine, Dayton four, Providence four, and Henry Street one. A nurses' committee is common to all, a finance or ways and means committee to all but Henry Street.

All the organisations are private corporations supported by contributions and donations by interest on invested funds and by payment for services rendered. Providence receives in addition an annual subsidy from the city. Dayton supervises city paid nurses.

In methods of administration, there is on the whole a general uniformity. All the organisations have a director or superintendent of nurses, all place the staff nurses under supervisors or head nurses, all require that a doctor be in attendance if a case is to be continued, all receive fees from patients, all give free service to those unable to pay, and all require an eight hour working day of their nurses.

Dayton gives care in small districts to all types of cases by a single nurse.

Henry Street and Providence have separate groups of nurses for special branches of the work.

Post-graduate courses are offered by Henry Street, Boston and Cleveland in connection with colleges.

Practical training is given pupil nurses by Cleveland and Providence.

Hourly nursing on a paying basis is undertaken by Cleveland and Providence.

Contagious nursing is done by Cleveland and Chicago.

Industrial nursing is done by Henry Street, Boston, Cleveland, Chicago and Providence.

A separate obstetrical staff is maintained by Henry Street.

Country homes are maintained by Henry Street and Day-
ton.

Visiting housekeepers or domestic educators form part of the staffs of the Boston, Chicago, Dayton and Providence associations.

Homes for the staff nurses are not provided by any of the organisations, though a few of the Henry Street nurses live at the Settlement and the Boston Association owns the house used for headquarters, in which also some of the officers and post-graduate students live.

During the year 1914–1915, the Committee on Organisation and Administration of the National Organisation for Public Health Nursing, of which Mrs. Arthur Aldis was chairman, prepared a model constitution and by-laws for nursing organisations, with suggestions also as to certain regulations concerning administration. This constitution, together with the various notes and suggestions, was revised, clause by clause, at the Third Annual Meeting of the National Organisation for Public Health Nursing. It has also been approved by an expert Parliamentarian.¹ Owing to lack of space, the valuable notes which elaborate the by-laws are omitted in the following pages.

SUGGESTIONS FOR CONSTITUTION AND BY-LAWS OF NURSING ORGANISATIONS, MADE BY COM- MITTEE ON ORGANISATION AND ADMINISTRATION OF THE NATIONAL ORGANISATION FOR PUBLIC HEALTH NURSING.

1. The name of this organisation shall be
..... Its location is

2. The objects for which it is formed are the providing of skilled nursing care for the sick in their own homes and the teaching of hygiene and sanitation.

¹ Mary Plummer. Author of "Ready Reference on Principle Parliamentary Powers."

3. The management of the aforesaid organisation shall be vested in a Board of Directors, consisting of a President, Vice-President, Secretary and Treasurer, and other directors, officers and one-third of the directorate to be elected each year by the members of the organisation assembled at the annual meeting. Each director shall be elected for a term of three years.

N.B.—Application for charter should be made after consultation of state laws regarding corporations. Names and addresses of persons forming the Association should be given.

BY-LAWS

Sec. 1. Any person by the annual payment of \$ or more becomes a member of the Association.

Sec. 2. There shall be held once a year in the month of January an annual meeting of these members, duly advised by the Secretary at least one week in advance, for the purpose of listening to reports of the work, and electing officers and directors for the ensuing year.

Sec. 3. At the annual meeting members shall constitute a quorum.

Sec. 4. Preceding the meeting the President of the Association shall appoint, outside of the Board of Directors, a Nominating Committee, whose duty shall be to prepare a ticket to present to the members for election.

Sec. 5. Immediately after the annual meeting, and before the next regular meeting of the Board of Directors, the President shall appoint from the Board of Directors the Working Committees for the ensuing year, presenting the appointments to the Board for ratification. A two-thirds vote shall be necessary to ratify.

Sec. 6. Duties of officers. It shall be the duty of the President to preside at all meetings of the Association and of the Directorate; to present, or cause to be presented, to the members at the annual meeting a full and complete report of the finances and work of the Association for the preceding year; and to appoint all committees.

Sec. 7. It shall be the duty of the Secretary to keep the

records and minutes of meetings and to attend to the correspondence pertaining to the work of the Association.

Sec. 8. It shall be the duty of the Treasurer to receive all moneys of the Association, to deposit them in such bank or banks as the Directorate may indicate, and to keep a true, accurate and detailed account of all moneys received and paid out. Checks may be signed only by the President and Treasurer. In the absence of the Treasurer, the President shall appoint in writing from the Directorate a Treasurer pro tem, notifying the bank in writing of the temporary change.

Sec. 9. There shall be held, on the of every month, a Directors' meeting, due notice of which shall be sent not less than four days in advance, to each member.members shall constitute a quorum.

Sec. 10. There shall be a committee formed, of members of the Directorate, for every department of work.

Sec. 11. Special meetings of the Directorate may be called at any time by the President or at the written request of any three members.

Sec. 12. The object for the special meeting shall be stated on the summons, which need not be sent longer than twenty-four hours in advance, and no other business shall be considered at the meeting.

Sec. 13. Resignation of officers or directors may be accepted by the Board at any regular meeting, and vacancies filled until the next annual meeting.

Sec. 14. Absence of any member of the Directorate from three consecutive regular meetings without sufficient excuse being sent to the Secretary shall be deemed equivalent to resignation, and shall be acted upon as such unless otherwise ordered by a two-thirds vote of the Directors.

Sec. 15. It shall be the duty of each Director to aid the Association by obtaining donations and subscriptions and by assisting the work according to his or her ability.

Sec. 16. These by-laws may be modified, repealed or amended at any regular meeting of the Directorate by the affirmative vote of two-thirds of the Directors, due notice of the proposed change having been given in the summons to

the meeting. Such changes should be presented at the annual meeting for the approval of the members of the Association.

SUGGESTIONS IN REGARD TO NURSES' DUTIES, SALARIES, PROMOTIONS, ETC.

1. Only graduate and registered nurses are eligible for Public Health nursing. Graduates of training schools in good standing, not registered in the state where they are to be employed, may be received on temporary appointments until given an opportunity by the state to qualify for registration.

2. Applicants for nursing service should be in sound physical condition before reporting for duty. It is desirable that a physician's certificate be obtained.

N.B.—It is customary for nursing organisations to have detailed application blanks to send out on demand, giving information as to requirements.

3. Salary. Qualified Public Health Nurses should receive for the first year not less than \$75.00 a month. This salary should be raised at the rate of \$5 per month for the first few years, after which the salary is at the discretion of the Board of Directors, taking into account the nurse's value to the Association and to the public. Sometimes a salary of \$60 to \$65 a month is offered during a probationary period. Promotion in salary should not be made merely at the end of a given period, but should be earned by the nurse's proving herself increasingly valuable.

N.B.—Adequate "qualification" implies either post-graduate education in public health work or experience under the direction of some Visiting Nurse Association which furnishes thorough supervision.

4. Hours of Duty. A fair working day for a nurse is from 8:30 A. M. to 5 P. M., with one hour at noon for lunch and clerical work. Nurses unable to finish their visits within this time should keep a record of all over-time work. Sunday visits are usually not required unless in the case of very sick patients, where a day's absence would be a great disadvantage. Each nurse should be given at least one-half day a week.

N.B.—It may be arranged that one or more nurses as

required be subject to call for duty on Sunday. This obligation may be taken alternately, so that those not on call may know themselves wholly at liberty.

5. Vacations and Sick-Leave. A nurse doing Public Health duty should be given one month's vacation a year on full pay. This time should be conscientiously used for rest by the nurse and no other duty undertaken. During a nurse's absence due provision should be made by the Board for a substitute.

In case of severe illness a nurse should receive her full salary for two weeks. After that her position should be reserved for her a reasonable time without salary.

N.B.—Some associations find it possible to do more than this. Most nurses have little or no means of support save their own salary. In case of illness, especially if contracted in the districts, a Board of Directors will naturally desire to exercise generosity and consideration. It is difficult to make rules on this subject, as each case will need to be judged on its own merits. It is not conceivable that a contributor to a nursing organisation could possibly object to such a use of his contribution.

6. Savings. It may be found desirable to have a committee of Directors, possibly one or two members of the Nurses' Committee, who will take an interest in the question of nurses' savings. The members of this committee should inform themselves as to sickness insurance and use their influence to impress upon the nurses their serious obligation, both to themselves and the Association, of putting by a certain portion of their salary as provision in case of need.

7. Residence. Nurses are advised to live within reasonable distance of the district to which they are assigned, and must be provided with home telephones.

8. Uniforms. Nurses accepted on the staff should be required to wear the uniform of the Association when on duty. This should be a dress of washable material, long coat and untrimmed hat. The strictest personal neatness in dress should be required at all times. It is customary for nurses to provide their own uniforms, although some Associations provide coats and hats.

9. Save for a few simple and specified remedial measures for the first visit, and it is necessary that these be allowed by the local medical associations, nurses should never be allowed to give care save under the direction of the physicians.

10. It is not expected that nurses will be called for night duty; but in a case of emergency where this is necessary provision should be made for the care of their patients during the following day.

11. When nurses are expected to attend infectious cases, such visits should be made at the end of the day, and the utmost strictness in quarantine measures observed.

12. A nurse should not accept personal presents of money from patients or friends of patients. If such are offered, she should always explain that payment is to be made to the Association, and give a receipt for every amount so collected, no matter how small.

13. It is desirable that calls for nursing service shall be accepted from all sources. It should be explained at once that the nurse gives care only under the physician and must never be regarded as a substitute. After a first visit, further visits must rest upon the nurse's decision as to the need.

14. Nurses should never attempt to influence the religious or political opinions of the patients or to influence patients in the choice of a physician. Where there is no physician in attendance and the family does not know whom to summon, she may give advice.

15. Nurses should be expected to keep careful records of their cases on record-cards provided for the purpose. Time should be allowed in the working day for the reports, and one of the most important activities of the National Organisation for Public Health Nursing has been the preparation of standard record forms. These serve the purpose of providing accurate histories and also form a means of comparison of statistics. It will be readily understood that statistics kept on a different basis are useless for purposes of comparative study.

16. Giving of material relief is outside the sphere of the visiting nurse. Any cases requiring such aid should be reported to the committee or directly to the agency whose prov-

ince it is to provide for such need. The nurse, however, may be empowered to relieve an emergency need until such time as her committee or the relief agencies can act. This "Emergency Fund" may be increased to include such expenses as a night nurse, or a relief nurse, or the transportation of a patient, etc.

17. Save where there is no other nursing service to be obtained, nurses should not be expected to attend maternity cases at time of delivery, but of course will answer calls to patients after confinement.

PART III

SPECIAL BRANCHES OF PUBLIC
HEALTH NURSING

CHAPTER I

TUBERCULOSIS NURSING

TUBERCULOSIS has for centuries been recognised as a disease to be dreaded. Hippocrates (460 to 377 B. C.) described it as the disease which is "the most difficult to treat and which proves fatal to the greatest number."¹ As early as the fifth century B. C. a Greek physician also recognised it as transmissible through contagion, and this view was maintained at intervals throughout the middle ages by European writers. It will be a surprise to many modern advocates of registration and compulsory segregation to know that "in Naples a royal decree dated September 20, 1782, ordered the isolation of consumptives and the disinfection of their apartments, personal effects, furniture, books, etc., by means of vinegar, brandy, or lemon juice, sea water or fumigation. Any violation of this law was punished, if the individual was an ordinary mortal, with three years in the galleys, and if he happened to be a nobleman he was sent for the same time to the fortress and had to pay 300 ducats. The physician who failed to notify the authorities of a tuberculosis patient was fined 300 ducats for the first offence, and a repetition of the neglect would banish him from the country for ten years."¹

Notification laws also existed in the eighteenth century in Spain and Portugal, for the purpose of insuring the disinfection of the patient's personal effects after his death.

¹ Dr. Knopf, "Tuberculosis. A Disease of the Masses." Prize essay.

During the first half of the nineteenth century, however, little attention was paid to the theory of infection. It was not, indeed, until 1865 that a French doctor actually demonstrated the transmissible nature of the disease, a demonstration which antedated Dr. Koch's discovery of the bacillus by seventeen years.

In America the tuberculosis campaign, as a special movement, may be said to date from 1885 when the Adirondack Cottage Sanatorium was started by Dr. Trudeau at Saranac. Soon afterward anti-tuberculosis societies began to spring into existence, Pennsylvania having the honour of establishing the first one in 1892. In 1905, when the National Association for the Study and Prevention of Tuberculosis began its active work, there were in the United States thirty-nine anti-tuberculosis associations and committees. Ten years later fifteen hundred such associations existed, including thirty-five state organisations.¹

In spite, however, of the rapidity of recent development, it is but a short time since consumption was accepted by the general community as an inevitable scourge and one which it would be of little use to try to overcome. The disease once recognised the patient was considered doomed, and if he were fortunate enough to belong to a loving family, it was their privilege only to make his remaining days as comfortable as possible. This was apt to be accomplished by keeping him warm and out of all draughts, incidentally out of all fresh air as well. If poor, his days were spent by the kitchen stove, and because of his wretched nights he was rarely left alone. In many instances space being scarce, the night care was given by a member of the family, who for convenience shared the bed of the sufferer. When a year or two after the death of the patient this devoted nurse succumbed to

¹ Leaflet published by the National Association for the Study and Prevention of Tuberculosis.

the disease, the scene was re-enacted in all its details, while sympathising friends regretted that the Blanks "had consumption in the family."

The isolation of the tubercular bacillus in 1882 and a consequent study of its habits threw new light on the subject, while the assertion that tuberculosis was not hereditary but was transmissible, and if recognised in time was by no means hopeless, changed the whole situation.

Dr. Weist makes the startling statement that prominent medical writers believe pulmonary tuberculosis to be one of the most universal and benign of all the diseases with which human beings are afflicted. This seemingly paradoxical statement is based on the statistics gained from autopsies, a series of Nagel showing that between the ages of eighteen and thirty, ninety-six per cent. showed evidence of tuberculosis.¹ Other reliable studies according to Dr. Hamman, Physician in Charge of the Phipps Dispensary, Baltimore, inform us that ninety per cent. of the human race is tuberculosis affected and that infection occurs at a very early age, so that at twelve few children have escaped it.²

As all these people have not died of tuberculosis, what has cured those who have lived to die of something else, or rather what has made it possible for them to withstand the presence of the bacilli? This is the important question, and, generally speaking, the answer has been, that in the resistive power of the individual has lain his ability to throw off the disease. How to avoid infection, and strengthen this resistive power in both well and sick, has been, aside from scientific research, the principal problem to which the modern tuberculosis movement has devoted itself.

¹ Dr. H. H. Weist, "Treatment of Pulmonary Tuberculosis." *American Journal of Nursing*, October, 1912.

² E. N. La Motte, "The Tuberculosis Nurse." Introduction by Louis Hamman, M.D.

The modes of infection, whether by means of milk from tubercular cattle, whether from houses previously inhabited by tuberculosis patients, or whether only by direct contact with the patient, the length of life of the tubercular bacillus under favourable or unfavourable conditions, the degree of susceptibility to the disease inherited from tuberculous parents, have all been points of vigorous discussion. All, however, have agreed that the length of time during which the individual has been subjected to infection, and the degree of vitality possessed by him, are two of the most important factors in deciding whether or not he shall succumb. It is because of the consensus of opinion on these points that the public health nurse has found herself so important a factor in the campaign. It is from the standpoint of her work alone that we shall consider the tuberculosis situation in the present chapter, though in doing so we are well aware that, important as her work undoubtedly is, she is but one link in the chain of agencies dealing with the vast problem.

Bedridden tuberculous patients have for years been cared for by general visiting nurses, but it was not until 1899 that the first attempt in America was made to provide systematic home visiting for the tuberculous as a class. The initial step was not taken by nurses, but by two women medical students in Baltimore, who under Dr. Osler's direction, followed to their homes the patients coming to the Johns Hopkins' Hospital Dispensary, instructing them in regard to diet, fresh air and the disposal of sputum. This work, though undertaken for the purpose of education and relief, partook largely of the nature of an investigation, and the results proved interesting. The social aspect of the situation was recognised from the first, for the students were instructed to co-operate with the Charity Organisation for relief, and with the Board of Health in regard to sanitary conditions. The results of the first year of work were of such a nature that the sug-

gestion was made that if nurses could systematically undertake it, bringing their special training to bear upon the practical problems involved, more might be accomplished.

It was not, however, till November, 1903, that the necessary funds were forthcoming, and a nurse took over the work of the medical students, beginning a regular system of visiting. A few months previous to this, in the winter of 1902-1903, the value of a special nurse for tuberculosis had been recognised in New York, and a nurse engaged by the Charity Organisation, while a little later such work was undertaken by the Vanderbilt Clinic. Special tuberculosis nurses were in 1904 appointed almost simultaneously by the Baltimore and the Cleveland Visiting Nurse Associations, each acting without a knowledge of the plans of the other. Though Miss Nora Holman was first appointed by the Baltimore Association in March, 1904, she and her successor, Miss Woodward, only continued the work for a few months respectively, and in June, 1905, Miss Ellen N. LaMotte, whose name is so well known in connection with tuberculosis nursing, undertook the work in Baltimore. Meanwhile, in June, 1904, Miss Elizabeth Upjohn had been appointed to this special service in Cleveland. Miss Upjohn's early death fortunately did not occur until she had done noteworthy pioneer work for the tuberculosis cause both in Cleveland and in Boston.

Everywhere the campaign was hopefully begun. It had been learned that tuberculosis was infectious through the entrance of the tubercular bacillus into the alimentary or respiratory tract, and it seemed a simple matter to tell the people how to avoid infection. It had been found that power of resistance to the bacilli was increased by healthful living conditions, therefore it was felt that instruction, and the building of sanatoria where the early cases might be assured of the three fundamentals, fresh air, good food

and rest, was all that would be necessary. Great stress was laid on the educational value of the sanatoria. The arrested cases were expected to go forth as missionaries, not only taking excellent care of themselves, but preaching everywhere the doctrines of prevention which they had learned. It was hoped, therefore, that by the erection of a sufficient number of sanatoria supplemented by the city dispensaries to diagnose cases and the corps of nurses for home instruction, with quite incidentally a few hospital beds for the dying, the campaign, if vigorously pursued, need not necessarily be a long one, and in a few years tuberculosis would be, if not eradicated, at least greatly diminished.

Sixteen years of such effort have taught us many things. They have taught us that an incalculable number of difficulties, having their roots deep in the social structure of our cities, enter into the problem. They have taught us that the average returned sanatorium case does not become a teacher of the doctrines of prevention, but that on a return to unhealthful living conditions, he, too, often succumbs to a relapse of his own disease, and unfortunately usually proves no better than his neighbour in regard to the care of himself, or the protection of others. They have taught us that the hopeless and almost unalterable conditions of poverty produce not only the soil in which tuberculosis will flourish, but also produce in many instances a weakness and shiftlessness of character on which it is impossible to graft the intelligent self-sacrifice so necessary if a tuberculous patient is to be harmless at home. Last, but by no means least, they have taught us that isolation of the advanced case is necessary if we are to avoid crop after crop of infection, and we have learned, alas, that such isolation cannot as a rule be accomplished at home.

The tuberculosis problem has many aspects, each of which presents itself with varying emphasis to different

workers in the field. That every social condition which affects the living and working conditions of the individual also affects the problem cannot be denied, and from out of the mass of effort it is difficult to determine the amount of credit due to any one phase of the work. Many false starts must be made, and time and money be wasted in such an enterprise. Possibly some day a seemingly simple discovery may enable us to do away with all but one type of effort, or to apply some already used weapon in a way more potent for results. Lord Lister, in working out his great discovery of the theory of antiseptics, merely applied carbolic in a different way. It had already been used as a deodorant in the very wards where hospital gangrene flourished. Perhaps present day tuberculosis workers will live to see either the discovery of a vaccine, or the new application of some already known principle which will replace the slow and often blundering methods of to-day. Meanwhile results, though not statistically brilliant, are being obtained, for in places where the tuberculosis campaign is being vigorously waged the death rate is steadily falling.¹

A tuberculosis nurse in beginning work must arm herself with two characteristics for daily use, hopefulness and patience. Without the former she will find her work too depressing; without the latter hope will soon die, for there is so little of visible success except as a survey is taken covering a period of months or years. In entering the tuberculosis field there is one point which she must bear constantly in mind: that although she deals largely with the individual, her problem is a community problem. Though she cheers and nurses the patient, though she procures aid for his destitute family, though she preaches far

¹ It has been estimated in this country in the registration area that between the years 1905 and 1913 the death rate from pulmonary tuberculosis fell from 166.7 per thousand to 127.7 per thousand. Leaflet printed by the National Association for the Study and Prevention of Tuberculosis.

and wide the doctrines of healthful living, she will have barely touched the problem unless she prevents the spread of infection. Indeed from the strictly community point of view she may do more harm than good by prolonging the life of the patient and so increasing the length of time during which he is a source of infection.

It is difficult to speak of the menace of the open case without seeming hardness of heart. There is no more pathetic object in the world than the advanced tuberculous patient, or one which should so call forth the tender helpfulness of the nurse. Her sympathy, however, must not allow her to forget her function of protector of the health of the community from infection. From the tuberculosis standpoint the inhabitants of any city or town may be said to be divided into three groups: those who are well; those who are ill, but for whom there is hope of recovery, or partial recovery; and those who are in an advanced stage of the disease and who provide the principal source of infection. Much as we long to help the pitiful members of the latter group, it would be a false sentiment which would do so at the price of drawing from the first group recruits for the other two. The nurse who stands by the bedside of the dying consumptive, and with quick sympathy asks herself the question, "How can I help this poor soul?" must learn to follow it instantly by the even more important and truly sympathetic one, "How can I keep others from a like fate?"

The different stages of the disease naturally form a circle to which there is no beginning and no end. It is rather curious in the light of later experience to consider the point at which the pioneer workers thought it best to penetrate the circle and begin their work. Seeing the suffering of the advanced case, they quite naturally said: "Let us go back of this hopeless stage; let us spend our time on the early cases and cure them before they become advanced. In that way we shall do away with tuberculo-

sis." They forgot that back of the hopeful early case in the vicious circle lay the advanced case, spreading always bacilli, and infecting more new individuals than the workers could hope to reach. Sanatoria were built by states, municipalities and private enterprise, the doors of which were tightly shut against the hopeless cases, though in the same community there might not be provision of a single bed for them. The dispensaries also quite naturally expended their energies on the early cases. Nurses gave what care and instruction they could to the dying and hurried on to give of their best to the men and women who might hope to recover.

After a few years of work, data and the nurses' own personal experience sounded the note of alarm. From an economic and community point of view what was the use of a vast expenditure of time and money, if so large a percentage of the patients who died at home transmitted their disease to other members of their family? Consistent, systematic precaution against the spread of infection is almost more than we expect of the great majority of our district patients, because such care presupposes a high degree of intelligence. With no previous knowledge of the underlying principles of the germ theory, unused to consideration for others, often untrained to habits of personal cleanliness, and living under conditions which make isolation most difficult, how can we expect that instructions, no matter how carefully given, will be rigidly observed? Too many nurses who for years have had a family under observation, and have expended untold effort upon them, have seen one member after another develop suspicious symptoms and after more or less resistance finally succumb to the disease. Looking back five years, such a nurse is often forced to admit that if the ignorant affectionate husband and father could have been removed from the lounge in the kitchen to a hospital bed, the whole sequence of events might have been changed.

It is generally conceded by tuberculosis workers the country over that with our present knowledge time and money cannot be better spent than in the effort to obtain hospital care for the advanced cases. To accomplish this hospitals must be made attractive, and they must be so situated as to make it possible for the family and friends of the patient to go and see him there. No affectionate family will willingly send one of its members to die among strangers, too far from home to be visited.

When appropriations are being made for the building of tuberculosis hospitals, it has often been possible for nurses, at public hearings and otherwise, to set forth the point of view of the poor in this respect. It is not always understood what railroad fares mean to them, and how little accustomed they are to even short journeys.

If hospitals are available, there are three ways by which patients may be induced to enter them: by persuasion, by coercion, and by laws making possible the forcible removal of the wilfully careless. There should, of course, be no question of the last two methods until the first has been tried to the uttermost. In the use of persuasion lies the nurse's greatest power. She must remember, in exercising it, that it is to the friend they find in her that the people will turn. Sincerity, as in all the other relations of life, must be the foundation on which the desire to serve is built. After every effort of persuasion has been brought to bear without success, the question of applying the second method, that of coercion, must be considered. Of course, if the patient's family is self-supporting, and he refuses to leave home, it is merely a question of withholding the nurse's own services for bedside care. If, however, as is often the case, material relief has been furnished at the nurse's request, the problem is a more complicated one. By many experienced tuberculosis nurses, notably Miss Ellen N. La Motte, it is felt that all relief, and all actual nursing, everything indeed which increases the

temptation to remain at home, should be withheld from the dangerous patient who persistently refuses to enter a hospital.

Miss La Motte, feeling strongly that the crux of the whole tuberculosis question lies in the segregation of the advanced case, says, "A nurse must always bear in mind that her chief work is the prevention of tuberculosis; it is not necessarily the prolongation of human life, although the two are sometimes coincident. Relief should be asked for if it bring about the prevention of tuberculosis, but under no circumstances if it means increased opportunities for scattering the disease. Under the latter conditions, assistance should be withheld or withdrawn as the case may be."¹

Each situation must be dealt with individually, but whatever may be the plan of action, in no instance should the nurse cease to visit the family for advisory purposes, if permitted to do so for however hopeless it may seem her efforts ought only to cease with the patient's death.

As regards the third method that of compulsory segregation, some states and some cities have on their statute books laws permitting the wilfully careless consumptive to be forcibly removed to a hospital under certain conditions.² There are few nurses having a long experience of tuberculosis work who have not longed for the support of such

¹ Ellen N. La Motte, "The Tuberculosis Nurse."

² Victor G. Heiser, M.D., Ex-Director of Health, Philippine Islands and Director for the East, International Health Commission, Rockefeller Foundation, states that in the State of Victoria, Australia, compulsory isolation of all tuberculous patients who do not prove careful has played an important part in the remarkable results obtained there. He says, "I have recently been advised that the enforcement of these rules (registration of cases, with subsequent following up, compulsory isolation when desirable, and physical examination of immigrants to prevent the entrance of the tuberculous) has resulted in the disappearance of tuberculosis in the State of Victoria." The death rate for the entire country of Australia is eight per thousand. V. G. Heiser, M.D., "How the State of Victoria, Australia, Secured Control Over Tuberculosis." *Out-Door Life*, January, 1916.

laws. In certain cases they would doubtless greatly strengthen the nurse's hands, but in this country the relief would be tempered by the insufficiency of hospital accommodation, which makes the selection of cases so difficult. For every vacant bed there are usually a dozen patients on the waiting list who ought to be put into it, and it is not always the one who would fall under the provisions of such laws who is doing the most harm. Many a seemingly docile patient who is constantly surrounded by a devoted family and a roomful of friends may be a greater source of danger than another who openly refuses to take precautions, but who spends his days and nights alone. Laws for compulsory hospitalisation, if they are to be effective, must provide in some way for retention of the patient after he has once entered the hospital. Many departments of health, having power under ordinances regarding communicable diseases to send patients to hospitals, have no power to keep them there involuntarily. On the whole, at the present time in this country the nurse will do well in her efforts to induce her patient to leave home, to pin her faith to persuasion backed up by coercion. Both have mighty power if rightly applied.

At the death or removal of an advanced, or indeed any open case, it is the nurse's duty to superintend the cleaning of the room or rooms which he has occupied. Here her efforts will probably be simplified if she works under municipal control. Different cities have different arrangements regarding fumigation. In some, it is done with care and consistency, in some it is a mere farce, and in others no provision is made for it at all. While fumigation is perhaps valuable if properly done, with a just computation of the amount of fumigating material required and careful attention to the stopping of all apertures, it is worse than useless if done in a less conscientious way, for the people look upon it as a kind of charm that will exorcise the evil spirit of the disease, and relieve them

of the necessity of using soap and water. Whether a room is fumigated or not, a thorough house-cleaning is a vital necessity, and about the details of this the nurse should inform the family with the greatest care. None of the rooms which the patient has occupied at all should be neglected. Where no municipal steam steriliser exists, the question of the destruction of such articles as can neither be washed nor boiled is a most difficult one. In some instances a charity society may be willing to replace bedding, etc., which the family could not otherwise afford to destroy, but at best the nurse will need all the common-sense and good judgment with which she has been endowed if she is to attain the maximum of safety with the minimum of financial loss.

No effective tuberculosis campaign can be carried on without the free clinic or, in very small places, some other provision for free diagnosis and medical care. It is not only desirable to secure patients in the very earliest possible stage of the disease, but it is also desirable to keep a watchful diagnostic eye on those who, though not ill, have been severely exposed. Such people, if poor, will rarely consent to pay a doctor's fee, even if by an effort they could afford it, for what seems to them a perfectly useless precaution.

If, as sometimes happens in pioneer work, the engaging of a nurse has been the first step taken, her every effort should be directed toward the establishment of free clinics, for without diagnosis she is utterly powerless. Nor must she feel that having secured such provision for medical care it is enough for her merely to be present at her clinic or dispensary. The attendance at clinics will as a rule prove a very good index to the activity of the nurse. They will be well or ill-attended in almost direct ratio to the success of her work in the homes. It is easy for a nurse to grow a little careless about clinic attendance, and to rely too much on her own exertions in home visiting. All old

cases should present themselves regularly for examination, and new undiagnosed cases should be constantly brought in. Indeed the finding and bringing under observation of new cases hitherto undiagnosed is one of the most important of the nurse's duties. It is estimated that for every recorded death from tuberculosis, there are five other people who have the disease, while some authorities double this number. Nurses should never feel that they are covering their community unless they are reaching approximately such a number.

Every legitimate clue must be followed in finding patients, but in doing so a nurse is confronted with, perhaps, the most serious difficulties of her work, in the doctor who without thorough examination, insists that his patient has only a cold, or the one who having made a correct diagnosis does not believe in telling the patient or his family the truth. If a case has been diagnosed as positive by reliable authorities and bacilli found in the sputum, the nurse is placed in a most trying situation when the patient transfers himself to another physician who tells him that he is suffering from bronchitis. Unless absolutely forbidden the house she will do well to continue her visits, giving, of necessity, no advice, but holding her friendship with the family against the day when another turn of the wheel of fortune brings the patient back to the dispensary or to a physician with a different attitude of mind. Quite as difficult is the nurse's path when a physician after diagnosing a case as positive refuses to acquaint the family with the real situation. It is absolutely impossible under these circumstances to inaugurate the routine procedure necessary to secure the protection of the patient's family and friends. Again the nurse is forced merely to await developments, though she may comfort herself with the thought that so great has been the change in the point of view on this subject, she may well look forward to the time when the number of undiagnosed cases, or those

from whom the truth is withheld, will be a negligible quantity.

When a case has been diagnosed and the patient told the nature of his disease, it is often a question how far a nurse's responsibility extends in her effort to safeguard the health of the community from infection. It is generally conceded that while the patient remains at home her responsibility cannot be too strongly emphasised, for it is there, where he spends the greater part of his time, that the greatest danger lies. As we have seen, danger from infection is in more or less direct ratio to the length of time to which the individual has been exposed. Short or isolated exposures are comparatively harmless. For this reason we may safely assert that the home is the principal centre of infection, and the nurse's time and energy may be proportionally expended.

Much anxiety has been felt in regard to the infection spread by the homeless man who drifts from lodging house to lodging house, spending perhaps a night or two in each. While it is desirable that the whereabouts of every one suffering from tuberculosis should be known, these drifters are less dangerous to the community than those who live continuously in one place. They are, however, pathetic in the extreme, and their removal to a hospital where they will receive care and attention is of course highly desirable.

As a large number of the patients on a nurse's visiting list are more or less able to work, she is continually confronted with the problem of how, and at what, they can work to the least disadvantage to themselves and other people. In the early days of the movement there was a great outcry for outdoor work for the arrested case, and many a good mechanic became a poor gardener or other outdoor labourer. Lately it has been felt that, as a rule, accustomed work, if done under fairly healthy conditions, is better for the patient than outdoor work for which he has neither the training nor the inclination. Also at his accus-

tomed work he has usually the advantage of being better paid, which enables him to maintain a higher standard of living.

As regards the danger of the tuberculosis worker to others, it is of two types, the danger to the customer or employer, and the danger to fellow workmen. It goes without saying that the most dangerous occupations to consumers or employers are those which have to do with food or domestic service, a cook, or one handling milk or other foodstuffs, taking precedence. Home laundry work if done continuously for the same customers is not safe, but other work having to do with neither food nor personal service need not be feared. For the fellow workmen the danger naturally depends upon the carefulness of the patient. It is often a difficult matter to persuade a man who is willing to take every precaution at home to carry sputum cups to his work. This is so natural that the nurse can have nothing but sympathy with the desire to avoid conspicuousness or the possible loss of work. She must, however, press her point, and be ready to give whatever help she can to the employer who is willing to retain a tuberculous employé if directions are obeyed.

The ethical question as to whether a nurse, knowing that a patient is a menace to an employer or others, ought to give unasked information on the subject, is answered in different ways by different nurses and doctors. The responsibility is certainly a heavy one of knowing for a fact that the health of a whole family is being jeopardised by a careless tuberculous cook, or that delicate working girls, whose one asset is their health, are being served by a boarding-house keeper who threatens them with tuberculosis at every meal. The sympathy called forth by the cook and the boarding-house keeper, whose ignorance and carelessness are part of their general make-up, hardly exonerates the silence which has for so long given protection to those sick of this and other diseases, at the expense of the unsus-

pecting well. Of course the sick must be sympathetically considered, and the community which insists on its own protection in these ways cannot expect that the entire price of such protection will be paid by those already infected. A man who loses work which he is able to perform, because by performing it he becomes a menace to others, has a right to expect suitable provision for his needs at the hands of the protected community.

There is one method of spreading tuberculosis which for years has been a common one. This is the sending of the tuberculous patient to the country in the hope of improving his health. It is one of the nurse's cruelest duties to object to this, when a patient for whom there is no hospital accommodation lies suffering in the heat of a crowded city tenement. It is a duty, however, which she must not shirk, for it can never be anything but wrong to remove a consumptive from all supervision, and place him where he will become a new centre of infection to healthy people. Also, though it may often seem so desirable for the patient himself, it does not always prove so. Miss La Motte of Baltimore cites the case of fifty-five patients who were one summer sent to different farm houses in Maryland and Virginia. They were in all stages of the disease. Of the entire number, but two were distinctly benefited. Thirteen were temporarily improved, but soon lost what they had gained; thirty-two returned in worse condition than when they went, and eight died while in the country. In only one instance were the Baltimore nurses able to follow the results of these sad summer outings. In this household, three members of a hitherto healthy family became infected, all of whom died later, in addition to the summer boarder.¹

Surely we have dwelt long enough on the questions of infection and the responsibility of the tuberculosis nurse for the care of the well. Let us turn to the poor patient

¹ Ellen N. La Motte, "The Tuberculosis Nurse."

himself and see what can be done either to help him back to health or to alleviate the sufferings of his last days.

First, as we have seen, the nurse can secure for him early diagnosis, that he may set about the tedious task of getting well as soon as possible. If he is considered capable of continuing at work she can see that by co-operation work is provided which can be done under possible conditions, and she can help him to so arrange his free time that it may be spent to the best possible advantage. If he is unable to work, she can secure for him, again by co-operation, sanatorium treatment, or the means to obtain the needed rest and proper food at home. Fortunately for the peace of mind of the nurse the expensive milk and egg diet so universally recommended a few years ago is no longer considered desirable by most physicians, a less highly concentrated and less fatty diet being usually preferred.

As regards the whole question of relief, the nurse will do well to leave this entirely in the hands of the co-operating relief society, merely placing at its disposal all helpful information, and making up her mind to abide by its decisions. These may not always be wholly to her liking; it would be a miracle if they were, but on the whole, the best work will be accomplished by the type of co-operation which permits to both nurses and relief agency complete control of their respective departments. The pleasanter the personal relations maintained between the two, the simpler it will be to obtain the best results for the patient.

There is one danger for the patient likely to recover which is too often overlooked. In the effort to cure him physically he may be made a moral invalid. Every tuberculosis nurse has had the experience of joyously watching the return to health of a patient on whom every effort of many agencies has been expended, only to find that when well, nothing would induce him to return to regular work of any kind. "Why work when financial

assistance is so easily obtainable?" seems to be the attitude of mind. This is most natural, and should be guarded against as far as possible by the wise nurse. Relief when needed should be graciously and generously given, but the patient and his family should be helped to regard it as purely temporary, and encouraged to look forward to the time when it will not be needed.

In visiting a new case a nurse must not allow her zeal to carry her along too fast. It is as unprofitable to try to teach the family at a first call all that she wants them to know as it would be to try to teach a child the entire alphabet in one lesson. In the first place, they cannot take it in, and in the second place they will be so discouraged that they will not want to take it in. Owing to the nature of the disease there is no need for haste, for a few days, more or less, will not make any particular difference, and it is far better to build a firm foundation for future teaching, and avoid antagonising the family, than to lose all by trying to do too much. A nurse new to the work is often rather shocked at the slowness and caution of the older workers in this respect, but she will do well to take a leaf from their book. The psychological effect will usually be better, if on her first call the nurse dwells principally on such things as make for the patient's comfort and relief, leaving for later calls insistence on less welcome details.

As a rule a new patient should be visited very frequently for the first few weeks, both because instruction is best given in small doses, and because the more quickly a friendly relationship can be established, the better. Everything should be carefully explained, and the nurse must look into all the details herself, leaving nothing to chance or the probable intelligence of the family. Lavish expenditure of time at first will often prove a saving in the end. Her instructions will include arrangements as to the patient's diet, and regulation of his hours of rest

and time spent out of doors. She will also make provision for his sleeping, if possible, in a room alone, and certainly in a bed alone, and will help the family to arrange the sick room to the best advantage. She will teach the use of sputum cups or other prophylactic supplies, and will arrange for separate dishes, towels, etc., for the patient, not forgetting that she will have to make a point of the separate washing of these articles.

The question of exercise will usually be decided by the doctor. As a rule none is allowed if there is a rise of temperature, or, of course, after a hemorrhage. If the patient possesses a fair degree of strength, the nurse will have to be very explicit as to what constitutes time spent in the open air. A woman will often report a number of hours spent out of doors, when a closer inquiry will elicit the fact that she took a closed car at the corner and got out at the door of a crowded department store where she spent two fatiguing hours among the bargain counters, and returned to her home in another closed car. Such a patient will have to be taught with infinite patience that the putting on of a hat and coat and leaving the house is not "taking the fresh air treatment."

An ingenious nurse will find many ways of getting her patients out of doors, pressing into her service flat roofs, back yards, tiny porches, and other seemingly impossible places. If, however, none of these open-air spots are to be found, it is better that a patient should sit for a certain number of hours each day well wrapt up at his own open window than that he should take an exhausting walk to a park, or try to get his fresh air about the streets. If a patient is to sleep out, or sit out, he must be kept warm. Artificial heat, hot water bottles, hot bricks or soap stones should be added to warm clothing on cold days.

For some patients, particularly those who have not the resource of reading, enforced idleness is a misery, and the hours spent in "sitting out" seem interminable. The

nurse must realise this, and do her best to keep up his spirits, and encourage the family to bring to him what cheerfulness they may.

When a patient returns from a sanatorium, or recovers sufficiently at home to resume his work, he should be most carefully watched. A return of any of the old symptoms, temperature, cough, pain in the chest, loss of strength, night sweats, shortness of breath, or rapid pulse, should be reported to the doctor. There will usually be a slight loss of weight with the resumption of a normal life, but this, too, should be watched for and reported.

If a patient is not improving, but is obviously losing ground, he had better be encouraged to stay in bed, rather than allowed to use up his little strength and spread further infection by struggling to keep about. Even if unfortunately he must go to bed at home, instead of in a hospital, he will still be more comfortable and less dangerous to others than if permitted to drag himself about the house. The care of the bedridden tuberculous patient does not greatly differ from the care of patients ill with other diseases, except for the one point of precaution against infection. Bed-sores will have to be carefully guarded against as they are a common danger, and, owing to the prevalence of night sweats, frequent bathing will be necessary if the patient is to be kept sweet and clean. Indigestion is so common an accompaniment of tuberculosis in all its stages that the nurse must give time and thought to the question of diet. In the last stages, particularly, much suffering may be saved by care in this particular point. The last days and weeks of the patient's life if necessarily spent at home are apt to be very hard on the members of his family. The nurse must do her best to see that overwork and loss of sleep do not so weaken their resistive power as to make them an easy prey to infection.

The tuberculosis problem for the intelligent nurse often seems to present so many aspects as to prove positively

bewildering. Her responsibilities, if classified, may present themselves somewhat as follows:

First. The prevention of the spread of infection.

Second. The finding of new cases.

Third. The care by instruction or nursing service of the patients who must remain at home.

Fourth. Co-operation with other agencies for the good of the patient or of the community.

Fifth. Her duties at clinics or dispensaries.

Sixth. The keeping of such records and statistics as will simplify her own work, and help to clarify the problem as a whole.

A word as to the nurse's health. Is such work dangerous for her? Years of experience would seem to imply that it is not. At the same time it is as hard, or harder, than any other form of public health nursing, with the element of infection added, and to do it safely the nurse must keep herself in good condition. If she falls below par, she would do well to turn to some other form of work, at least until she is built up again. A nurse capable of instructing her patients ought not to need to be told the simple rules of health, but, if it were not human nature, it would be surprising how diverse her preaching and practice often are. Everything that has been said about overwork may well be doubly emphasised for the tuberculosis nurse, not only on account of physical resistance to infection, but because the nervous strain of this special form of work is so great.

It is usually found wise that a physical examination should be made of all nurses desiring to do tuberculosis work, and that such examinations should be repeated at frequent intervals. The first examination prevents the physically unfit from undertaking the work, while subsequent ones make possible the early detection of trouble. All examinations should be made by specially selected physicians. It is not enough that the tuberculosis

nurse should have a sound chest. The work is often discouraging in the extreme, and for those who work at it daily such discouragement is apt to insidiously sap the nervous strength. For this reason, both for the sake of the nurse herself and also of the work she is doing, it is rarely well to continue indefinite specialisation in tuberculosis work. The question of endurance does not come up when tuberculosis is taken as part of the work of a general nurse. When special nurses of a large staff are set apart for the work, it is a comparatively simple matter to make such changes in the staff as will react to the advantage of all. When, however, the tuberculosis work of a city is done by a staff of nurses controlled by a separate body it is a little more difficult, but even under those circumstances, temporary exchanges may be made, which will secure already trained public health nurses to the tuberculosis staff, and will at the same time give valuable tuberculosis training to the nurses thus exchanged. If, therefore, a lagging interest, a feeling of hopeless depression, or a fear of the disease, fails to yield to the usual antidotes of rest or a little pleasure, let the nurse prepare to make a change, for she may be quite sure of two things; first that her work is not good for her, and secondly, that she is not good for her work.

Tuberculosis presents no simple problem. It is confined to no class, or race, or country. It is no respecter of age or sex. Its victims are to be found in great cities, in small towns, in pleasant villages and in the scattered farm houses of lonely districts. It has existed for centuries. To fight it, the laboratory, the hospital, the sanatorium, the educational propaganda, the fresh air school, the public health nurse, and all the less direct means of raising the standard of health, are required. The tuberculosis nurse must be possessed of courage and devotion of a high order, and must be able to see the work she is doing in such perspective as will raise it far above the

discouraging details on which so much of her time must be spent, to a height where it will appear to her what it is, a great work, worthy of the best that she has to give to it.

CHAPTER II

CHILD WELFARE NURSING

WHILE no effort will be made in this chapter to deal with the question of preservation of infant life except as it touches the work of the public health nurse, we cannot refrain from a brief historical outline of the subject, taken from Dr. Holt's admirable address at the Fourth Annual Meeting of the American Association for the Study and Prevention of Infant Mortality.

In his address Dr. Holt points out that the infant problem is as old as the human race, and has merely changed its aspect at different periods of the world's history, and among different races and peoples. Among savages and barbarians it was a question of getting rid of superfluous children when the food supply was limited. Later, among more advanced nations in which the fighting power of the man was the test of his valuation to the state, the weak and deformed, and in some instances and under certain conditions the girl children, were exposed to death, as an economic measure. In other nations, such as Sparta, the vigorous, strong babies, which had been favourably passed upon by a committee and allowed to live, were most carefully reared, with the result that the Spartans became the finest race of their time. In early Rome, the father, not the state, had the power of life and death over the child, an old custom requiring that the new born baby be placed by the midwife on the ground. If the father desired the child to live, he raised it in his arms invoking the goddess Levana; if not it was at once ex-

posed to death. One wonders what effect this moment of suspense had upon the helpless mother's condition. Hardly a nervous strain to which we would care to submit our present day obstetrical patients!

In some places the children were left in the woods, or exposed in certain parts of the cities; in others, drowned, while occasionally their sacrifice became part of a religious rite. The motives, however, for infanticide have everywhere been much the same; famine, poverty, or the promotion of natural efficiency by the elimination of the weak.

After the opening of the Christian era, the church, not the state, began to interest itself in the infant question, and gradually began to assume the care of orphans, and children abandoned by their parents. It was in the sixth century at Trèves that the first cradle, a marble one, was placed outside the door of the church to receive any child that might be placed there. This example was followed by many churches and some hospitals, but the practice of infanticide apparently died hard, for in Rome, as late as the end of the twelfth century, the bodies of so many babies were caught in the fisherman's nets in the Tiber that the heart of Innocent III was moved to pity, and he arranged to have infants received in the Hôpital due Saint-Esprit.

In the early part of the fourteenth century the Hôpital des Innocens was founded in Florence. After this other hospitals opened their doors to babies, but it was not until the seventeenth century that special institutions for foundlings began to come into existence in the various countries. These were almost invariably under the auspices of the church, the state still taking no heed of its babies, though with the foundation of the Society of St. Vincent de Paul in 1638, some influence was brought to bear upon public authorities to make them acknowledge the civil existence of foundlings.

There are no statistics to tell of the infant mortality of those days, but judging by the results of the same conditions on babies at the present time it must have been appalling. It seems to have been an accepted fact during the seventeenth and eighteenth centuries, that of the children born, the greater number should perish in infancy or childhood.

Even royal babies were no exception; Queen Anne left no heir to the throne of England, and yet she bore eighteen or nineteen children, only one of whom survived even to his eleventh year. The historian Gibbon lost six brothers and sisters in infancy. If this was the case where presumably the best knowledge of the time was available, what must it have been with the children of the poor? A French medical journal of 1780 makes the statement that in France half of the children born died before the end of their second year.¹

Very gradually the opinion grew that this state of things, so long peacefully accepted, was not inevitable. Philanthropists and doctors, principally the latter, began to question its necessity and to inquire into its causes, and, toward the end of the eighteenth century, even to suggest reforms.

It is hard for us to realise that the introduction of the practice of vaccination should have greatly affected infant mortality, but the writers of the day tell us that smallpox caused the death, before their tenth year, of one-fifth of all the children born, and that a third of all the deaths of children were due to this cause.²

With the publication of a little book in 1817 entitled "A Cursory Inquiry into Some of the Causes of Mortality Among Children with a View to Assist in Ameliorating the State of the Rising Generation in Health, Morals

¹ President's Address, Fourth Annual Meeting of the Society for the Study and Prevention of Infant Mortality.

² *Ibid.*

and Happiness" began the preaching of the modern gospel, and its author, John Bunnell Davis, may be regarded as a pioneer in this field. He advocated maternal nursing and public dispensaries for children, and he says, "If benevolent ladies could be prevailed upon to form district committees to visit and inspect the health of sick, indigent children, much practical good would result from a medical and moral point of view. By such visitations as these it may be predicted that the instances of mortality among children will be quickly diminished: at the same time that such benevolent females corrected the absurd notions and errors of the poor as to the domestic management of their children."¹

What have we in these "benevolent females," but the forerunner of the modern infant welfare nurse?

The reduction of the death rate following the introduction of vaccination was unfortunately only temporary, for about this time two of the most prejudicial influences against infant life began to make themselves felt, and even to this day affect enormously the infant death rate. One is the rapid growth of the modern city with its consequent congestion, the other the employment of women in factories. It is a well-known fact that during the cotton famine in England and the siege of Paris in France, both times of great suffering and a high mortality for adults, the infant death rate fell, for the very simple reason that the mothers stayed at home with their babies.

Many of the important organisations affecting child-life, now common in other countries, originated in France, among them the Crèche or day nursery, the Society for the Protection of Infancy, and a Society for Nursing Mothers. This last society approached the subject from a different viewpoint, and sought to save the child by

¹ President's Address, Fourth Annual Meeting of the Society for the Study and Prevention of Infant Mortality.

caring for the mother both before confinement and during the nursing period.

With the recognition of the social aspect of the problem began legislation tending to preserve infant life. The first Acts were directed against the crying evils resulting from the unlicensed boarding out of babies, and later ones against the employment of women in factories, either immediately before, or immediately after, confinement.

Laws against such employment were passed in Switzerland, Hungary, Austria, Belgium, England, Germany, Portugal and Norway in the latter part of the nineteenth century, and in Spain, Sweden and Denmark the first two years of the twentieth.¹

During the latter half of the nineteenth century also, the question of infant mortality was taken up by various national social science or hygiene societies, and since 1890 national congresses for the special consideration of the subject have multiplied rapidly.

Dr. Holt assigns this very recent awakening to various causes, differing somewhat in different countries. For the world at large, however, he feels that the humanitarian motive has been the strongest, and, in America, the chief motive.

Among the European nations, especially France with its falling birth rate, the economic aspect has probably been uppermost. A third influence Dr. Holt believes to lie in the progress made in sanitary science and preventive medicine, by which it has been shown what is possible in hygiene and public health.

Whatever the motives, the methods employed to save the babies have not greatly differed in the various countries.

The fundamentals have been, a higher standard of

¹ President's Address, Fourth Annual Meeting of the Society for the Study and Prevention of Infant Mortality.

special education for the physician, with a better obstetrical service; free baby clinics or consultations; home visiting with instruction for the mother both before and after the birth of the baby (special stress to be laid on maternal nursing); a clean milk supply; and instant medical attention easily available either in or out of a hospital, for the sick child.

In different countries and localities, different methods and ways have been tried.

In Paris, before the war, a weekly stipend of a few francs was given to nursing mothers to enable them to stay at home and care for their children, a method which greatly aided in securing regular attendance at the consultations.

We have learned now that war measures for the preservation of infant life have been attended with remarkable results in Paris. At the beginning of the war a central office was opened for the assistance of pregnant women and babies. Seventy-four per cent of the 16,579 births occurring during the first five months of the war took place in institutions. The maternal mortality was about 20 per cent. less than that of the same period in 1913, and the infant mortality, 30 per cent. less. The mothers were all able to nurse their babies at first. The number of abandoned children was less by half, and the infants of 1914 were superior to those of previous years, averaging 15 per cent. higher in weight.¹

Germany has been particularly successful in dealing with the problem of illegitimate babies. In Leipsig, the illegitimate child becomes at birth the ward of the municipality. It can be put out to board only with persons publicly authorised, and it must be brought monthly to municipal offices for examination. The result is that

¹ "The Prenatal Problem." Mrs. Max West of The Federal Children's Bureau. Sixth Annual Report of the American Association for the Study and Prevention of Infant Mortality.

the illegitimate infant death rate is half that of other babies¹ instead of being far higher, as is usually the case.

Some of the methods employed have been novel. In Huddersfield, England, in 1904, the mayor announced that he would give a pound sterling to the mother of every child born during his term of office, who presented it living and well at the end of a year. A committee of ladies was formed to visit and advise the mothers. The death rate of infants in that district fell from one hundred and thirty-four, to fifty-four, per thousand. One wonders just what proportion of credit should go to the committee of ladies and what to the pound.

In New York, the director of the division of Child Hygiene of the Health Department formed a league of "Little Mothers" for girls from twelve to fourteen years of age with the object of teaching during the summer vacation months the principles of infant feeding and hygiene to these girls who already have so much care of younger brothers and sisters, and who later will become mothers themselves.

Various American cities have also made use of the summer outing for mother and baby, the floating hospital, and the baby day camp.

In this country, as in England, one of the most important factors in the campaign against infant mortality is the public health nurse. It is a recognised fact that on her intelligence and skill depend in no small measure the results of this great humanitarian effort.

A Frenchman has said that a baby consultation is worth just as much as the physician who conducts it and no more. In this country we can add the nurse's name to this epigrammatic statement, for without her help in the

¹ President's Address, Fourth Annual Meeting of the Society for the Study and Prevention of Infant Mortality.

homes the work of the best physician will be so hampered as to be unproductive of good.

The infant welfare campaign is a great fight against ignorance, one of the hardest foes to contend with, and the nurse fighting, perhaps alone, is sometimes only conscious of her own failures and of the strength of the enemy. She should take courage, for the war is being successfully waged the world over. In city after city results show that it is no hopeless task which has been undertaken, only a difficult one—two vastly different things.

New York City presents probably the most difficult aspect of the problem, with its great and constant influx of every foreign element, and its congestion which in certain districts is unequalled in any other city in the world, yet what has been accomplished there in the last few years may well kill discouragement forever. In 1880 the infant death rate in New York was 288 per thousand of living infants. According to the last statistics of the Board of Health for 1915 it has fallen to 98.2.

As Dr. Holt points out, these amazing results have not been accidental, but have been brought about by hard work, enthusiastically carried on, and by means of a carefully planned campaign with liberal appropriations on the part of the city authorities.

As essentials of the New York work he names:

Visits of trained nurses to the homes of ignorant mothers of newborn babies.

Extensive development of the milk depot, and infant consultation.

Federation in one organisation of all agencies engaged in infant welfare work.

Leaving aside the last two factors let us apply ourselves to a consideration of the first; the visits of trained nurses to the homes.

As a rule so-called infant welfare nursing is done in one

of two ways; by the general visiting nurse, as part of her regular work; or by special nurses, whose whole time is given to babies or children. The former is apt to be the method pursued in the country and small towns; the latter in the larger cities. In either case, it is vital that the nurse should feel the importance of this branch of her work and realise that she must keep up by reading, correspondence or attendance at conventions with the newer methods being employed, for a baby is not merely a little adult, but presents its own special problem for those who have eyes to see it.

We have learned that time is a most important factor in all work with children, so quickly do they respond to every good and bad influence, and we have learned that we cannot begin our work with them too early.

As we have seen, in the last century in France the Society for Nursing Mothers understood that to be successful with the baby the mother must be the earliest consideration, and that he who waits for the birth of the child makes but a late beginning.

We must leave to others the field of eugenics, though the public health nurse should not be wholly ignorant of this most interesting subject. As she goes about her district she should be fully aware of the menace of the feeble-minded girl, or other defective or degenerate type with which she comes in contact. As day by day her training and experience carry her back of each effect to its cause, she will realise that part of her work as a child welfare nurse must lie in reporting such cases to proper authorities, so preventing if possible the continuance in another generation of such mental, moral and physical disabilities.

The baby, once on its way, must be saved, and given every chance, not only of life, but of health. Those who cheerfully assert that the best thing we can do for a forlorn child is to let it die, frequently forget that death

is not always the issue. If it were really a question of dying or living, it would often be more merciful to expose our delicate babies in our public squares, as is the custom even to this day in some countries, than to allow them the lingering death of starvation and neglect. The most vigorous exponent of the theory of the survival of the fittest would hardly go comfortably to his business through such a square, and when it is a question, not of death, but of a long life, spent with the wretched handicap of an injured constitution or physical defect, surely time and money spent in prevention of these conditions is time and money well spent. A delicate and forlorn childhood, also, does not necessarily mean a useless manhood or womanhood, for even were bodily perfection improbable, who shall say that the only gifts to the world are made by those who have physical ability?

Taken for granted then, that every child has the right to be well-born, and after birth properly cared for, how can public health nurses bring this about?

The best time to begin is with the mother as near the beginning of pregnancy as possible. Usually the difficulty lies in getting hold of the patients as early as is desirable. In the country, where the nurse is well known to every one, it is perhaps easier than in the city, where conditions are somewhat more complex, but there are many avenues of approach if they are only made use of.

First, every doctor should know that prenatal work will be undertaken, also the lying-in hospitals and the various hospital out-patient departments. In most instances, unfortunately poor patients do not come to the notice of physicians or institutions until well advanced in pregnancy, and many who employ midwives, or call a doctor at the last moment, receive no advice whatever before confinement. Other means, therefore, must be used to get in touch with these women. Where baby work is undertaken by special nurses, the information at the

disposal of the regular visiting nurse must not be neglected. Often cases may be found through charity organisation visitors, church workers and other like sources, provided a method of routine notification can be devised.

The moment that the nurse acquires patients in these irregular ways, she becomes involved in the difficulties of professional responsibility. Her first effort must be to induce the patient to see a doctor, and tact will often accomplish this. There will remain, however, a large number who never have had, and never will have anything but a midwife. This situation is met differently in different cities. In some, if the patient is unwilling to see a physician, the case is dropped; in others, it is held for general advice; in still others, if after tests for albumen, all is well, the case is admitted and carried until the midwife is called. If albumen is found it is rarely difficult to induce the patient to consult a doctor, if she is told the situation.

In any event, the fact that these women need the assistance of nurses should not be lost sight of, and every effort should be made to solve the problem of adequate care for them.

In many places, an unfortunate situation exists, by which the child becomes the responsibility of four distinct groups of nurses, his age being the determining factor in the division of this responsibility. Prenatal nurses are responsible for his welfare before birth; obstetrical nurses give him his first care; at two weeks of age he is handed on to infant welfare nurses, who may, or may not keep him, until with the beginning of his school life the school nurse assumes the final responsibility.

Even to a lover of specialisation this must seem a poor arrangement. It often arises because different agencies have undertaken these different phases of the work, and not infrequently, this well-cared-for child is nobody's responsibility between the age of two years, sometimes one,

and the time he goes to school. Surely this is a waste of forces. Why should not one group of nurses be entirely responsible for him at least until he enters school, with the possible exception, for purely practical reasons, of the brief period when his mother becomes an obstetrical patient? Practically, it is difficult for the nurse to give obstetrical care and at the same time meet the other obligations of child welfare work. Almost invariably the obstetrical case will be attended to, at the expense of the chance half-way talk with the mother whose baby is just beginning to ail.

Where it has been tried, however, it has been found that continuity is not lost, by referring the patient to other nurses for this short period, though naturally the situation is simplified when both groups are under one management.

If the baby needs care, and if the child of school age needs care, any arrangement which does not recognise his needs between these two ages is obviously absurd.

This is the most important period of all for many orthopedic troubles, and on the nurse's trained observation, and vigorous action often depend the child's whole future life. Many a cripple would not be dragging out a weary inactive existence had he been somebody's responsibility at three years of age.

As school nursing has in many cities become a municipal responsibility, so there is a very evident tendency on the part of municipalities to take over infant welfare work. If this is done, the work should be undertaken by them as a whole, and the child cared for from the earliest possible period of his mother's pregnancy until the work of the school nurses is complete.

As actual bedside nursing is rarely undertaken by municipal nurses there would be no difficulty in calling upon a private association for obstetrical care for the mother, or other nursing assistance in time of illness,

without in any way lessening the continuity of responsibility and oversight exercised by the city nurses.

School nursing, which presents its own special situation, will be dealt with in the following chapter. We will, therefore, only consider here the duties of the nurse who carries the responsibility of the child from before birth until school age. Such a nurse must be interested in all the phases of early childhood, for, having children of different ages on her list, she will be at one and the same time dealing with many aspects of child-life.

Help and advice to the expectant mother form one distinct line of work; another, giving or securing good obstetrical care; a third, securing for the baby the four requisites for health: proper food, fresh air, sleep, and suitable clothing, with all that is implied in the question of food and housing.

The child from a year to three years of age presents a fourth and wholly different set of problems, both as regards diet and other needs. At this age, children who have been improperly fed reap what has been sown, in the many results of rickets, crooked legs, crooked backs, and other defects which, if unattended to, will make them cripples.

A little later, the nurse has to concern herself, not only with the child's physical welfare, but with his moral surroundings as well. Homes which have not been wholly unsuitable for a baby spell moral ruin for older children.

These varied interests bring the nurse in contact with a number of problems, and with a number of other agencies, for she quickly finds herself a cog in a complicated bit of social machinery.

She forms her own opinion of the effect of factory work on the pregnant woman, and of the early return to such work on the mothers of young babies. The midwife problem claims her attention, for she must know how to obtain good obstetrical care for her patients. She is an

important factor in the mothers' conferences, or well babies' consultations, and she also learns to have very definite knowledge as to the milk supply of her city.

She is aware of the condition of the licensed boarding houses for babies, and recognises the importance of their strict supervision. The housing question is a live issue to her, and she knows, only too well, the results of low wages or unsteady work on physical health. Play grounds and clean back yards become to her matters of importance. A good children's nurse is a familiar figure in the offices of charity organisations and all the children's aid societies, because she must use the resources at her command.

Some of her time must be given to group instruction of mothers, and to public talks, while in the summer she is kept busy arranging for summer outings.

Her connection with the hospitals which admit children is a close one, a routine visit to the home of each discharged child often being found of great advantage.

The young unmarried mother is always one of her greatest difficulties, and through her the whole question of moral influences for children is opened up. The vital and morbidity statistics of her city must be studied, for she is working for a definite end — the reduction of infant mortality and the improvement of children's health — and she must have an intelligent interest in such results as can be shown by city hall records. In addition to these local statistics, she may gain from the publications of the Federal Children's Bureau, and the meetings and reports of the American Society for the Study and Prevention of Infant Mortality, a wider insight into her subject.

All these things occupy the mind of the children's nurse, and perhaps sound rather confusing as enumerated, but they are so inherent a part of children's work, that they come to her as naturally, as the possibly more simple questions of purely medical significance.

So many means are now at the command of the nurse with which she may accomplish her ends and round out her work, that there are great temptations to absorb her time in other ways than in home visiting. Let it never be forgotten, that in this lies the principal strength of all public health nursing.

The entering of the home for purposes of instruction or ministration is the peculiar privilege of the public health nurse, and should always be the bulwark of her strength, and no other form of activity, or method of meeting the mothers, should be allowed to interfere with this special function.

It is an axiom with all advisory services of public health nursing that nothing should be told that can be shown by demonstration, and there is no place for such teaching as the home, where amid the usual surroundings and with the use of such utensils as are actually at hand, the danger of mistakes and misunderstandings is reduced to the minimum.

Rather, to the surprise of every one, really excellent results are everywhere being obtained from the teaching of home modification of milk, a process, with the more complicated formulæ, by no means simple. Such instruction is believed to be much better than the selling of prepared formulæ at milk stations, even taking into account the few women, too ignorant or careless to learn. The mother who masters the art is a better informed woman and is independent of the necessity of living near a milk station, and in addition more particular attention to the special needs of the baby is possible. Then, too, it should never be forgotten that the best artificial feeding is but a poor substitute for breast feeding, and for some mothers it is unwise to make the former too easy.

All are agreed that the mothers' conferences, or as they are called in some places, well babies' consultations, are one of the most important factors in the prevention of in-

fant mortality. At these conferences a doctor and nurse are always present, and to them the mothers bring their babies weekly for routine examination and advice. Sometimes milk is sold in connection with the conferences. As they are intended to act principally as preventive agencies, it is usual to send children found suffering from diseases other than those directly due to improper feeding either to their family physician, or to the hospital out-patient department. Even when this is done, however, the conferences serve a real need for these very cases, for many an acute condition has received early recognition which would probably have escaped the mother's untrained observation until valuable time had been lost.

There is a peculiar temptation in children's work for the nurses to carry cases without a doctor. Mothers who have themselves never had a physician, having made use of a midwife at the time of their confinement, see no necessity for taking a weak puny child to a doctor because he is not "really sick," though they are ready to ask the nurse's help and advice as they meet her on her rounds. These cases are difficult to deal with, though the mother's conferences have somewhat lessened the difficulty. It must not be forgotten, that diagnosis is a necessary preliminary to treatment, and that the nurse is not a diagnostician. Often a comparatively simple case has proved quite otherwise when brought to medical attention.

One of the greatest difficulties of children's work lies in the fact that it is apt to far outrun in its development its financial support, and once started, its limitation is well nigh impossible. There is rarely difficulty in gaining the confidence of the mothers among whom the nurses work, and each new home becomes a centre for further influence. In consequence the story is everywhere the same, the inability of the staff to adequately keep up with the work.

It is hard for a nurse who has worked long and diligently to induce the mothers to seek early advice for their ailing children, to say, when appealed to by just such a mother, "I cannot talk with you because I have more babies to care for now than I have time for, and there is no other nurse who is not situated as I am."

In consequence, it is common for children's nurses to carry a number of children to whom it is almost impossible to do full justice, and for the nurses themselves to have that driven feeling which reacts so unfavourably on their work. This should not be, for the old axiom, "That which is worth doing at all, is worth doing well," applies no less to child welfare nursing than to other things.

One way out of the difficulty may lie in the use of groups of supervised volunteer workers, who will save the nurses time by doing certain things for which trained service is not necessary, clerical work, taking children to hospital out-patient departments, carrying messages, etc.

It must be remembered, that no matter how intelligent and efficient these untrained workers may become, they should never be allowed to undertake the legitimate duties of the trained nurse, and boards of managers advocating such a scheme should bear in mind, that at first there will be little or no expense saved in actual time, because of the necessary expenditure of that valuable article for supervision.

To attain for any community a truly strong and efficient children's service, a sufficiently large staff of trained nurses working under proper supervision is essential, and to maintain this, the general public must be educated to its need, and to a recognition of the fact that the work must grow and will, if successful, inevitably require increasing funds.

A strong child welfare nursing service is potent for far reaching good, whether carried on by the unaided ef-

forts of a single visiting nurse, working alone in a country district, who cares intelligently for children as part of her work, or by the united efforts of a large staff of nurses who have at their command the varied resources of a big city. The greatest value of such a service lies in the fact that its primary function is to help others to help themselves.

The mothers are the natural guardians of their children's welfare, and those who can be so taught as to become practically independent of the nurse's help are the greatest successes, for above all, we must avoid killing or stunting the mother instinct of responsibility. If in our zeal, we educate a city full of parents ready and glad to relegate this responsibility to others, we shall have paid too heavy a price for any number of fat and healthy babies.

Miss Julia Lathrop, Chief of the Federal Children's Bureau, in speaking of the value of the nurses' work, tells an anecdote of a coloured mother of a fine strong child. In reply to a remark that the district nurse had done a great deal for the baby, the woman said, "Oh Lor' no, Miss, the district nurse didn't do nothin' for my baby. She just come and talked things over with me every week, and I was real glad to see her, but 'twas me, my own self, brung up this yer baby to be strong and healthy like he is. Nobody else could a done it."

This woman was right, nobody else could have done it.

The only real hope for the children lies in the education of fathers and mothers, and the strengthening, not weakening, of their natural feelings of parental responsibility.

CHAPTER III

SCHOOL NURSING

FEW Americans realise how slow their country has been to recognise the necessity of the systematic care of the health of the school child. As a matter of fact, the United States has been one of the last of the civilised nations to seriously consider the problem, though suitable provisions for health would seem to be a natural corollary of any system of compulsory education. France was the first country to make a beginning in the field of medical inspection, passing a royal ordinance in 1837 which charged the school authorities with the duty of supervising the health of the school children and attending to the sanitary condition of the school houses. These early beginnings in France, however, were not immediately followed by further development, and Brussels, meanwhile, by the appointment of regular school physicians in 1874 gained for herself the honour of being the first city to establish a system of school inspection in the modern sense of the term.

When in 1894 medical inspection was inaugurated in Boston, the United States merely followed the lead of France, Germany, England, Sweden, Russia, Austria, Hungary, the Argentine Republic, Chile, and Cairo, Egypt, which had all preceded her in such efforts.¹

The school nurse, however, has not made for herself the place in foreign lands which has been accorded her in the English speaking countries, a fact easily accounted

¹ Gulick and Ayers, "Medical Inspection of Schools."

for by the status of nursing in general and of all public health nursing in particular. There can be little doubt, that as the work of the nurse becomes better understood, there will be a greater demand all over the world for her services in the schools, for wherever she has made her entry, her value has been recognised.

Even in the early days and in the less complicated situation of a comparatively small place, we find an English doctor writing as follows: "When I first commenced my duties as school medical inspector in Wimbledon, it was impossible not to feel exceedingly depressed and hopeless with the work. As a doctor, I felt quite stranded in the strange atmosphere of an elementary school, coming into contact not so much with actual illness as with the primary conditions which produce or foster it; dirt, neglect, improper feeding, malnutrition, insufficient clothing, suppurating ears, defective sight, verminous conditions, the impossibility of getting adequate information from the children, or a knowledge of their home conditions, and nobody to whom one could give directions, or help one in examining the children. The only means of approaching the parents was to send an official notice that such or such a condition required treatment, and it was impossible, besides being outside my duties, to carry on any treatment at the schools. My duties began and ended with endless notifications, and there it all stopped as very little notice was taken of them."¹

Although other dates have been given, there seems little doubt that the first school nursing was started in 1892 in London by Miss Amy Hughes.² An inquiry into the question of the feeding of school children was at that time being made, and a request for the assistance of a

¹ Dr. Haywood, "School Nursing in Connection with District Work." Report of Jubilee Congress. 1909.

² "History of District Nursing in England and Other Countries." Amy Hughes, General Superintendent of Queen Victoria Jubilee Institute. Report of Jubilee Congress on District Nursing. 1909.

nurse came to Miss Amy Hughes, then Superintendent of Queen's Nurses in Bloomsbury Square. Miss Hughes determined to answer the call herself, and her weekly visits to the school in Wild Street, Drury Lane, revealed the fact that much unnecessary suffering existed among the children, caused by uncared for minor ailments, and that in consequence there was much loss of school time. Miss Hughes's efforts were followed by the placing of Queen's nurses in a number of London schools, and in 1898, by the establishment of the London School Nurses' Society. This society, though doing such important work as a forerunner and example of what might be done, never itself undertook work on a large scale, as it was the policy of the association that school nursing was not legitimately the duty of a voluntary society, but should be financed from municipal funds.

The London School Board though apparently not antagonistic cannot be said to have been over enthusiastic about the scheme, if we are to judge from the following notice which appeared in 1900 in the *London Gazette*: "The School Management Committee give their consent to a nurse from the London School Nurses' Society attending each morning for an hour and a half to dress the eyes and sores of the children in those schools where the divisional members consider it desirable and make the necessary arrangements, provided that the Board shall not be liable for any of the cost thereof, and in any case where the school is visited by a nurse of the Society the Board provides a basin and kettle for the use of the nurse at a cost of three shillings for the two articles."¹

In 1900 we find this cautious Board experimentally appointing one nurse at a salary of seventy pounds a year to deal with what seems to have been an epidemic of a virulent form of ringworm. Though this nurse was not

¹ The School Nurse. Miss Honor Morton. Report of the Third International Congress of Nurses.

permanent, she must have added her quota to the evidence in favour of the work, for in 1904, urged thereto by the London School Nurses' Society, the London County Council took the matter into its own hands and appointed a staff of nurses under a superintendent financing the work itself. Thus school nursing was finally established in London. In the meantime, Liverpool always advanced in regard to public health nursing, had already started school nursing, the enterprise being paid for by voluntary contributions. Later other English towns and cities took it up, in some instances the nurse preceding the medical inspector and proving his need, in others following him as a necessary adjunct to his work.

It is interesting that in 1900, the secretary of the London School Nursing Society visited New York and, much impressed with the municipal system of school medical inspection, carried back to England plans for improving the then rather inert and ineffective methods of the medical officers of the London School Board. A year or two later Miss Wald of the Henry Street Settlement, New York, visited England and was equally impressed with the possibilities of school nursing. In this way, the pioneer work of each country brought inspiration to the other.

Previous to the day of medical inspection and school nursing, the helpless teacher had no choice but to exclude all children who seemed physically unfit to associate with the others, and in some cities, notably New York, the over-crowding of the inadequate number of school-houses made such exclusion seem occasionally the easiest way out. The finding by the Henry Street Settlement workers of a boy of twelve, who had never been to school on account of a tiny sore on his head proved on investigation typical of numbers of other children. In the early days, protection of the child in school was the principal object of medical inspection, and as far as it went the new order of things was certainly a vast improvement on past

methods, for compulsory education in districts where the people were unfamiliar with the ordinary laws of health and cleanliness had made of the schools veritable hot beds of major and minor contagion. Isolation of the infected children until they were cured seemed a wise and reasonable provision for the safety of the uninfected. Theoretically, also, the infected child was cared for, inasmuch as he took home with him a card stating the diagnosis of his case, and advising that a doctor be consulted. It was, of course, hoped that the parents would secure for him the necessary treatment and that in due time he would return to school wholly recovered from his difficulty. What actually happened was in many cases quite different. Though debarred from intellectual pursuits with his schoolmates, the mere possession of a card stating that he suffered from ringworm, scabies, or some other non bed-confining disease in no way interfered with his intimate association with them outside the school precincts. Indeed he was not infrequently to be found sitting on the curb-stone waiting for school to be dismissed in order that he might not lose a moment of their society. Thus the only object to be gained by his exclusion from school, the physical safety of the other children, was defeated. As for the excluded child himself, it was only in comparatively few instances that the card so carefully filled out was potent for good. Occasionally a parent understanding that something was wrong followed its suggestion and took the child to a doctor. In many instances, however, the child's incoherent account excited only the uncomprehending indignation of the parents. Why should not a mother object when told by her son that the doctor wanted him to have his eyes taken out and scraped?

Miss Wald realised that the natural result of school medical inspection without follow-up work was great loss of school time to the very children who were least fitted to lose a day, because they were those for whom, as a

rule, school opportunity ended with their fourteenth birthday. She, therefore, (in 1902) offered to place a nurse experimentally in four schools in New York showing a large number of exclusions, in order to prove the possibility of safely retaining the majority of the excluded children in school. The offer was accepted and the point so well proved by Miss Lena Rogers, now Mrs. Struthers, who undertook the work, that school nurses were promptly appointed by the municipality. During the single month of September, 1902, 10,567 children were excluded from the New York schools, while in September, 1903, with the nurses in attendance, there were but 1,101 exclusions. These figures are readily accounted for when it is considered that in many instances the causes of exclusion were pediculosis, ringworm, scabies and other troubles easily curable without loss of school time if vigorously treated, but of indefinite duration if allowed to go uncared for. With the advent of the nurse the policy of never ordering treatment was somewhat modified and routine treatment for such diseases as flavus, scabies, pediculosis, conjunctivitis, etc., was instituted.

The value of home visiting was early recognised. The New York Health Department has always asserted that the care given in school is the ameliorative, and that given in the homes, the preventive, work of the system. School nursing seems everywhere to have produced the same results, as far as the saving of school time for the child is concerned. Indeed, in England where certain of the schools are supported by a government grant based on per capita attendance, as well as by the local rates (taxes), it was found in several instances that the increased attendance of the children so increased the government grant (thus decreasing the rates) that the salary of the nurse was more than covered.

Care of the health of the school child has been developed step by step since the first school inspector was appointed,

and the work of the school nurse has shared fully in this development. The first systems of medical inspection aimed merely at the detection of contagious diseases, by which were meant measles, scarlet fever, diphtheria, whooping cough, chicken pox, mumps, etc. A short experience usually showed the desirability of considering likewise the parasitic diseases such as scabies, impetigo, and other diseases of the skin or scalp. At this point medical inspection has been inclined to halt, but in a rapidly increasing number of cities and towns medical inspection is being replaced by what is better described as medical examination, or health supervision, by which is implied a far more valuable piece of work. Dr. Porter, State Commissioner of Health of New York, defines medical inspection as "simply the search for communicable diseases" and medical examination as "the search for physical defects, many of which furnish the soil for contagion." It goes without saying that if the whole physique of a child is to be considered, with a view to obtaining a full knowledge of any physical defects, in order that he may be restored to perfect health, far more intensive work is required of the nurse than when it is merely a question of the safety and well-being of the other children, to be brought about through eradication of minor contagious diseases and isolation of the more serious ones.

As medical inspection in the narrower sense of the word is gradually being superseded by medical examination, it seems hardly worth while to consider the nurse's duties under the former system. Dr. S. Josephine Baker, Director of the Division of Child Hygiene of the Department of Health, New York City, says "There is even a greater need of a realisation that the type of school medical inspection that neglects to offer more than a superficial and routine inspection for the detection of contagious diseases and examination for physical defects is unworthy of serious consideration. Such systems are really a waste of

money and effort, and are even harmful in that they give the community a false sense of self-satisfaction, while the child is rarely permanently benefited, and the net result is usually the compiling of wholly superfluous statistics.”¹

The duties of a school nurse are, as a rule, more clearly defined than are those of most other public health nurses, though within their defined limitations there is ample room for the development of initiative. One requisite a school nurse must have, in addition to those usually required for public health nursing, is a love and understanding of children, without which much of the charm of her work will be lost to her, and also without which her own value will be greatly reduced. Her duties may, perhaps, be divided into three groups; her work with individual children at the schools, her work with individual parents at home, and her work as assistant to doctor and teacher in matters pertaining to health.²

All nurses are accustomed to work with doctors, but the teacher is a new element in the experience of most nurses, and the relation of the two positions in the school-room is occasionally misunderstood. A school nurse must remember that in entering a school building she enters the domain of the teacher, as in entering a hospital ward, an outsider enters the domain of the nurse, no matter what errand may have brought him there. For that reason, the tactful nurse will not only endeavour to work in the closest co-operation with the teachers, but will accord to them the deference due to those who stand somewhat in the position of hostesses. There are few teachers, who are not inclined to give a warm welcome to the school nurse as a co-worker who will simplify and render

¹ Dr. S. Josephine Baker, “Health Leagues as an Aid in Medical Inspection.” *Public Health Nurse Quarterly*, July, 1915.

² Time spent in home visiting is sometimes curtailed in order that the nurse may be at the school to assist the doctor during his visits. In many instances such assistance is not really necessary and the children are better served by an increase of home visits.

more valuable their own work, but it is not in human nature not to resent the presence in one's own domain of another worker who appears to have an air of taking possession. Let the new nurse, therefore, establish for herself the reputation of being a welcome *visitor* in every school-room, and let her preserve it by an unfailing attention to those small details of courtesy and simple politeness which count for so much in the daily routine of life.

Under different systems a nurse carries a varying degree of responsibility in regard to contagious diseases, but everywhere she is expected to do her part in the detection of early symptoms and the prompt notification of the doctor in regard to them. It is rare, and generally considered unnecessary, that the school doctor should see every pupil every day, and the suddenness of the onset of a number of the contagious diseases makes early diagnosis of the utmost importance. In carrying this heavy responsibility a nurse should thoroughly familiarise herself with the earliest symptoms of all the contagious diseases of childhood and keep constantly on the alert to detect them. Though she must avoid becoming an alarmist it is wiser to err on the side of too much reporting rather than too little, for the stakes are high and a little carelessness may lead to very serious consequences.

The Massachusetts State Board of Education has issued a most helpful pamphlet entitled "Some General Symptoms of Diseases of Children which Teachers should Notice, and on Account of which the Children should be Referred to School Physician," which also gives explanatory directions. The symptoms named are as follows:

| | |
|-----------------------|---------------------------|
| Emaciation | Eruptions of any sort |
| Pallor | Cold in the head with |
| Puffiness of the face | running eyes |
| Swellings in the neck | Irritating discharge from |
| Shortness of breath | nose |

| | |
|---|---|
| General lassitude and other evidences of sick- ness | Evidence of sore throat Coughs Vomiting |
| Flushing of the face | Frequent requests to go out. |

A nurse working in schools situated in the poorer districts will be obliged to spend a considerable proportion of her time on diseases of the skin caused by uncleanness, such as scabies, ringworm, impetigo and pediculosis. To the beginner these troubles may seem insignificant in that they do not threaten life, but there is, perhaps, no better test of a school nurse's efficiency than is shown by her power to deal with these difficulties, for in doing so her instructive ability is tested to the full.

For scabies, ringworm and impetigo, a routine treatment is usually ordered after diagnosis by the physician. Pediculosis is generally left entirely in the nurse's hands. For years pediculosis has defied the most vigorous efforts, principally because any treatment of the school child must be extended to other members of his family if it is to be of the slightest use. In this, as in all other efforts which involve the co-operation of the child or his parents, the nurse's power to deal with people will be called into play, and unless she possesses this power and is also able to raise the ideal of her work far above its sordid details, she will never be either a very happy or a very successful school nurse.

It is impossible to read any school health statistics without a feeling of amazement at the small number of children who are found to be free from some form of physical defect. A study of these statistics, however, is somewhat reassuring, for the finding of a child who is listed as "defective" on account of some easily remedied trouble such as carious teeth, enlarged tonsils or eye strain, ought not to be regarded as a cause for discouragement, but rather as a spur to action.

The defects to be looked for are those of the teeth, throat, eyes, nose, ears, nutrition, lungs, heart, nervous system and bodily structure.¹ Of these the most common are the four first named, teeth, throat, eyes and nose.

Within the last decade mouth hygiene has been acquiring a new significance, through the discovery that much general ill health is caused by a poor condition of the teeth. In the old days a dentist was consulted principally with a view to saving the teeth themselves, and those who could not afford dentists' bills merely kept each tooth as long as possible, and when toothache became unbearable had it extracted. When the number so parted with made mastication wholly impossible the remaining few were pulled out and a false set purchased. Modern scientific study has been showing us that not only are serious digestive troubles caused by such a method of treatment, but that carious teeth form centres of infection for disease and that a seriously lowered vitality may be directly traced to a general infection resulting from the absorption of pus from a diseased tooth.

The problem of caring for the teeth of school children in any adequate way is by no means a simple one, for statistics show that so large a percentage of children have defective teeth that the expense involved is very great. In England it has been met by beginning with the youngest children and continuing to care for their permanent teeth through their school life. As a new class is taken on each year and the others still retained, all will be under care in a few years, an end that justifies a means whereby many serious cases among older children have gone uncared for in the early years of the system.

Any method of dealing with mouth hygiene has two elements, the care of the mouth by dentists and the teaching of the use of the tooth brush to the children them-

¹ Gulick and Ayers, "Medical Inspection of Schools."

selves. In some places, the school nurses play an important part in both parts of this crusade, receiving through courses of lectures the necessary instruction which enable them to give talks on the subject and also to make examinations of the children's mouths. As in all other school work the influence brought to bear on the individual child is of the utmost importance, and the nurse must not let the necessity for this part of her work slip her mind in dealing with the children.

In the correction of such defects as those of the throat, eyes and nose, the nurse's responsibility will take the form of working in co-operation with the teachers to bring to the attention of the school physician all suspicious cases, and after diagnosis, explaining to the parents the notices sent them and persuading them to take the child to a family physician or free clinic for treatment; also, later in using her influence that the advice given may be acted upon. In these efforts as in the effort to induce cleanliness among the children new methods are being used.

A most important duty of the modern public health nurse has grown to be the teaching of self-help. The nurse who merely cares for her patients and leaves them ignorant of how to give this care themselves has long been considered a poor public health nurse. This theory has been carried a step farther in school nursing by the formation of what are known as hygiene or health leagues, the main feature of which is self-government by the children. Here the added impetus of concerted action and team work is given to the old theory of teaching the individual to help himself. Much of the school nurse's time has always been wasted in repeated visits to households where she has struggled in vain to induce the parents to secure proper treatment, to buy glasses, or to follow some desired line of action. Again and again she has been baffled not by opposition, but by the utter indifference of the whole

family. The situation when analysed is often a very simple one, the child himself does not want to have his head treated, is unwilling to go to the doctor or dentist, or does not like to wear glasses. Our forefathers would doubtless have been shocked at the independence of the modern child, particularly the forefather of foreign birth. Be this as it may, the fact remains that Johnny and Mamie, Ikey and Rachael, Toney and Marietta, together with numberless other small American citizens, whatever their antecedents, do very much as they please about a great many things. It, therefore, behooves the school nurse to secure the intelligent co-operation, not only of the children's parents, but of the children themselves. This, of course, she has been trying to do for years, but there is no stimulus like the public opinion of our peers, those who think as we think and whose actions are inspired by the same motives as our own.

In some cities, it has been thought wise to safeguard the child's dignity by the use of code numbers on his card to denote the nature of his disease, some designated number being used for the normal children, the object being that the other children should not know his difficulty. Under such a system, the incentive of general public opinion is lost and under it even with the most painstaking efforts of the nurse, such troubles as pediculosis may be said to have flourished and reflowered, breaking out again in many of the children almost as soon as cured.

The Health Leagues as organised in the New York Schools are proving so effective that a short description seems desirable. Dr. Baker says of them, "The government of the leagues is elastic, varying to suit the needs of the individual locality or the characteristics of the children, but the fundamental idea underlying all of the organisations is that the children are to be fully responsible for the government and the conduct of their league, that its appeal is to their self respect for themselves, their

class and their school and that the children through self-government are responsible for the cleanliness and health conditions and habits of all the pupils.”¹ Dr. Baker describes the general organisation as follows: “Each class elects two representatives to a general body. These two class representatives are designated as Class Leader and Secretary. They meet the nurse once a week for instruction and to report results obtained during the past week. Each morning, the class leader inspects each child in the class to determine conditions of cleanliness with reference to clean clothes, clean face and hands, clean scalp and well-brushed teeth. A record of conditions found is kept by the class secretary, the teacher acting as arbitrator in case of any dispute. Before the first inspection by the class leader, the plan is explained to each class, a thorough routine inspection of each child in the classroom is made by the school doctor or school nurse. A record is kept of every child needing attention as far as personal cleanliness or contagious eye or skin diseases are concerned. All children found in any degree physically defective are referred to the school doctor for special examination. Each child is informed of the nature of his or her defect or disease and the information is also given to the class leader. The nurse gives frequent talks in the class room on personal hygiene in order to stimulate the children to help themselves in obtaining health.

“Each classroom is provided with a banner or pennant stamped in gold letters ‘Hygiene.’ The pupils are informed that each class in which cleanliness is strictly observed and where all physical defects are either under treatment or have been treated will receive a gold star to be placed on the pennant. In classes showing a certain number of failures to observe proper care, but where the intent to do so is manifest, a silver star is placed on the

¹ S. Josephine Baker, M.D., “Health Leagues as an Aid in School Medical Inspection.” *Public Health Quarterly*, July, 1915.

pennant. In classes where the children seem indifferent and show little, if any, improvement a black star is given.

"Once each week or once each month, dependent upon the number of children under her control, the nurse makes a routine inspection of each child in the classroom awarding such stars as the children have earned. The co-operation of the school authorities has been shown in our work by the fact that the classes receiving gold stars are entitled to honourable mention from the platform at morning assemblies and the teachers of classes securing gold stars are permitted to carry their class pennant at the assembly as a mark of class distinction."¹

Through the influence of the leagues, the nurse's home visits have been reduced (though, of course, it is not intended that she should be wholly relieved of this duty, but only of unnecessary repetitions made for the purpose of reiteration of advice), physical defects have received more prompt attention, pediculosis, hitherto almost unassailable, has in some classrooms wholly disappeared, and according to Miss Kerr, Superintendent of Nurses of the Division of Child Hygiene of the Department of Health, New York, "cleanliness has increased fifty per cent. in the schools in which health leagues flourish."

Closely allied to the health leagues are the little mothers' leagues which are designed to teach girls from twelve to fourteen the care of babies, and incidentally to fit them for future motherhood. Such activities as these add greatly to the interest of a nurse's work and if she possess organising ability give new scope to her powers.

In all her home visiting, the school nurse will need to conform very rigidly to the rules laid down for her. It is an almost universal rule that school physicians are forbidden to make suggestions as to treatment of sick children, and the nurse naturally conforms to like restrictions.

¹ S. Josephine Baker, M.D., "Health Leagues as an Aid to Medical Inspection." *Public Health Nurse Quarterly*, July, 1915.

Indeed, technically speaking, school nursing is not nursing at all and differs from other forms of public health work in that though a diagnosis is obtained, treatment is not ordered. To the nurse used to different methods, this situation sometimes presents difficulties, for it is hard to see usual lines of treatment ignored after a diagnosis has been made by the school doctor. The nurse, nevertheless, must be content to play strictly the part assigned to her, even though often assailed by the temptation to overstep the mark for the sake of some individual child. She may as well accept the fact in the beginning that a family physician is quite likely not to order the treatment to which she has been accustomed, or even to confirm the diagnosis of the school doctor in whose opinion she places such entire confidence. She will be a very poor public health nurse if this does not trouble her. She will be a very poor school nurse if she tries to alter things on her own initiative, and if she does she will probably soon cease to be a school nurse at all.

Dealing as she does with the parents, wholly through her interest in their children, the school nurse has it in her power to either strengthen or weaken the bond between the foreign mother and her Americanised child. Few native born Americans realise the difficulties of these foreign women who come to the new country, too old in years and too firmly moulded by tradition to accept new standards or adopt different customs. It is, alas, unfortunately easy, in our efforts to give to the child an education which will fit him to his new environment, to take from him that most precious of possessions, a mother's influence. In the mere matter of questions of health his home and his school teaching are often, one might safely say, usually, at complete variance. If the child is quick and intelligent he easily assimilates the new doctrines, often gaining at the same time a most undesirable impression of his mother's ignorance. In his dealing with her he has a great advan-

tage, in that he and his brothers and sisters, and often his father, speak a language which she cannot understand. Indeed this occasionally goes farther, and the child so far forgets the tongue of his forefathers, or fails to acquire it as to make speech with his mother actually difficult. In this situation lies real tragedy, no less for the child unconscious of the value of his lost respect and reverence, than for the pathetic and bewildered mother. Let the school nurse, therefore, in her home visiting among foreign parents remember this tendency and do her uttermost to foster parental dignity.

In England and in Germany great efforts have been made to induce parents to be present at the physical examinations of their children in order that they may the more readily enter into all efforts towards securing their health. In this country little has been done in this particular way, though in a number of cities notices sent to parents calling attention to the existence of some physical defect, contain also paragraphs to the effect that the school physician will meet parents during office hours for further consultation and advice.

If the giving of talks, either to children or mothers at the school, form part of the nurse's duties, she should try to train herself to do this well. Talking to groups of children is not easy if one is unaccustomed to it, but is an art that can be acquired. It should be remembered that only such information or instruction as is actually understood is of any value. It is better to hold the children's attention for five minutes by a simple talk than to discourse most eloquently for half an hour to inattentive ears. By a wise and frequent use of questions very young children may be led almost to give the talk themselves, thereby arousing their enthusiasm and holding their interest.

In giving talks at mothers' meetings, simplicity and brevity are, perhaps, the most desirable attributes to cultivate, for it must be remembered that, as a rule, the audi-

ence is unused to the lecture form of instruction. When talking to foreign mothers great care should be taken in the selection of an interpreter, for a poor interpreter can spoil the best of talks. As the type of parents who attend the meetings differs widely in different parts of a city, a nurse must learn to keep herself sensitive to the atmosphere of her meeting, and if one method of interesting her audience fails, to try another until she finds herself successful.

A serious problem presents itself in towns or cities where free clinics do not exist, or where there is insufficient clinic accommodation for all the children requiring medical attention and whose parents are financially unable to procure it for them. It must be admitted that the establishment of free medical or dental clinics presents difficulties, but it is gradually being forced upon the attention of those interested in school health that without such clinics time and effort are not infrequently being wasted. This question is, however, outside of the school nurse's province, except in so far as her accurate and intelligent report of conditions as she finds them may help toward a solution of the problem.

Let no one feel that in considering the question of school medical inspection and the school nurse, it is only in the large cities that doctors and nurses are required. Investigations have shown that conditions in the rural districts are often truly lamentable, and offer as many examples of defective children as do the city schools. Indeed, it has been found that health statistics dealing with country school children, apparently living under the most desirable conditions, compare in reality unfavourably with statistics of city children living in the congested districts of large cities but with the advantage of good medical inspection and supervision. From the point of view of the city child this should be encouraging. From the point of view of the country child it should be a warning to be heeded.

The responsibility of records, in this particular branch of public health nursing, is one which does not usually fall to the nurse, but rather to the school authorities and medical directors. The best type of record is one which follows the child from grade to grade and from school to school, and it has also been found desirable that his scholarship record and his physical record should be placed on reverse sides of the same card, or at least that the two records should be filed together. The nurse's own reports should give an accurate account of the expenditure of her time.

The development of the scope of medical inspection has brought about an interesting change in methods of administration.

In the beginning, almost all the systems were administered by boards of health. Later, as the conception of the work broadened to include a responsibility for the whole physical welfare of the child, more and more commonly authority was vested in boards of education, rather than in boards of health. Now, it is quite generally conceded that as the number of exclusions (originally considered the principal if not the sole function of medical inspection) form but a small percentage of the work done, the logical authority should be that of the board of education. While the closest co-operation with the board of health is necessary, it is realised that divided responsibility, always productive of weakness and friction, is avoided if the board of education controls all work done in the schools. It is also felt that if doctors and nurses are to act as advisors to the teachers and school authorities in matters of general hygiene, such as lighting, heating and ventilation of school buildings, drinking water, supplies, the type of desks used, hours of study, recreation, etc., and if they are to give advice in regard to the teaching of delicate or nervous children, all such assistance will come with a better grace and will be more readily received if superintend-

ents and teachers, doctors and nurses are co-workers under a common authority.

Also since the child's physical record should form a part of his school record this matter is much simplified if all statistics belong to the record system of the board of education. Therefore, if school medical inspection aims at more than the mere detection of contagious diseases, the experience of many cities tends to show that it is best carried on as a function of the board of education, rather than of the board of health.

Nurses are usually placed under the direction of the medical inspector, but if the staff consists of more than a few nurses, a superintendent who is herself a nurse should be appointed and given the responsibility of selecting, training and supervising the members of the nursing staff.¹ All other systems of nursing work show that only through the intelligent administration of a nurse superintendent, vested with full authority within her province, can efficiency and evenness of work be maintained by any nursing staff, and school nursing is no exception to this general rule. That details of nursing work cannot be well taught or supervised by any one but a nurse is one of the earliest teachings of Florence Nightingale and one which over half a century of nursing experience in all of its various phases fully justifies.

As regards the amount of work which should be assigned to each nurse, it will, of course, depend somewhat on the type of children, and the distance of the schools from each other, as well as upon the demand made upon her time by home visiting. Experience in New York, Philadelphia and other large cities goes to show that a

¹ The system successfully inaugurated in Toronto, Canada, makes the nurses responsible to the Chief Nurse who is in turn responsible to the highest authority directing the system—the Board of Education. It is felt that the independence of the medical and nursing staff, except in medical matters, makes for strength and a minimum friction.

nurse should be provided for every 3,000 or 4,000 pupils in congested districts. In small cities of 20,000 to 30,000 inhabitants with a school enrolment of from 3,000 to 5,000 one nurse can usually manage the work if the schools are fairly near together. In very poor neighbourhoods where bad housing and insufficient nourishment produce their inevitable results, one nurse will be kept busy with 2,000 or 1,500 children.¹

The school nurse is not a passing experiment. She is a vital part of one of the most important of our national institutions. Through her work American citizens are physically fitted to receive the education which in its turn is to fit them for the responsibilities of citizenship. It is her duty to so teach the value of health both to children and parents as to make them realise that its attainment is worth some real sacrifice on their part; it is her duty to strengthen parental responsibility in new directions. It is her duty to strengthen the hands of teachers and physicians, and also to do her part toward making the American school an institution where bodies, as well as brains, are developed for a life of usefulness.

¹ Gulick and Ayers, "Medical Inspection of Schools."

CHAPTER IV.

MENTAL HYGIENE NURSING

THE miserable history of the care of the insane is too well known to require harrowing repetition. We have travelled far since the days of cruelty and neglect, but even yet in many states patients suffering from mental diseases are to be found in alms-houses and poor-houses, while the laws governing commitment to institutions in many places still have more in common with legal proceedings against a criminal than the admission of a suffering patient to a hospital for the sick.

It is interesting to trace the attitude of the public mind toward mental disease in the immediate past. Not so very long ago the main idea was to get rid of those who could not be fitted into a normal environment. Though friends and relations must always have suffered acutely, the community as a whole accepted the situation calmly enough. Later came the hope of cure by means of scientific diagnosis and treatment. Hospital care replaced alms-house care and that of the hardly less cruel asylum, and the community rejoiced at the return to health and usefulness of many who under an earlier régime would have passed their lives in exile.

At this point we seem to have paused. Diseases of the brain are still regarded by the general public not quite as are other diseases, and the mental hospital is only lately beginning to acquire the same status in the public mind that has been accorded hospitals for other types of cases. Also, and this is most important, the patient suffering from

a mental disease is still frequently allowed to go uncared for until his disease is far advanced.

In most physical disabilities we have been learning that early diagnosis and treatment are of the utmost importance if satisfactory results are to be obtained. We no longer wait until our babies become sick to visit them, but try on the contrary to deal with their health even before they are born. We do not wait till the tuberculous patient takes to his bed, but search for him in the highways and the by-ways in order to bring him under care while there is still hope for his improvement.

Illustrations of this effort to do preventive, rather than alleviative, work might be multiplied indefinitely, but it is too familiar to public health nurses to require more than passing mention. The same nurse, however, who is most zealous in her preventive campaign, whose trained eye is quick to see symptoms of either physical or social maladjustment, will often totally fail to detect early manifestations of abnormal mental conditions. This is not due to carelessness, but because until comparatively recently, we have been content to wait until a patient of this type showed such marked symptoms of his disease as to be wholly unmanageable at home. Disorders of the brain are not different from disorders of other parts of the human body, and the theory of the "stitch in time which saves nine" is not less applicable. Therefore nothing is more wasteful than a waiting policy.

The statistics of mental hospitals show that a large percentage of the recoveries give a history of an illness of short duration. Miss Katherine Tucker, in a paper read at the Mental Hygiene Conference of 1912, states that in the preceding year, of the five thousand and seven hundred first admissions to New York State Hospitals, ninety per cent. of those who recovered during the year had been suffering from insanity for less than a year before admission.

The public health nurse has a wonderful field of usefulness opening before her in this branch of nursing, for her intimate knowledge of home conditions often brings her in touch with situations which would not for many months be recognised as abnormal by others.

Insanity is not a single disease from which the disordered mind suffers, but is a generic term which applies to a number of diseases of the brain. These diseases spring from different causes, show different symptoms, run different courses and terminate in different ways, and each, therefore, naturally requires a different treatment. In some the first manifestations of trouble indicate the actual beginning of mental breakdown. In others, many danger signals are shown which to the ordinary observer pass as mere peculiarities of temperament, but which to the trained eye would be found full of significance. Unfortunately at the present time these early danger signals too often first come to the notice of a psychiatrist only as a part of the history of a patient already ill enough to be admitted to a hospital for the insane. Much of the treatment of mental and nervous troubles consists in its essence in the application of two principles, training and rest, or relief from strain. As more and more is also being done nowadays by organotherapy, baths and surgery, the value of an early diagnosis whereby treatment may be promptly secured will be readily understood. Even though many individuals showing well-developed symptoms of maladjustment and personal mismanagement do not eventually become insane, early diagnosis is none the less desirable, for much may be done by proper treatment to save them and their families from unnecessary suffering and discomfort. For those who stand at the cross-roads, unconscious that in one direction lies a normal life and in the other mental break-down, it is pathetic that in so many instances there is no helping hand to point the safe way, or to assist the helpless traveller to take it.

As yet the field of mental hygiene has been little developed for the public health nurse. The average visiting nurse does her best to bring under medical supervision the cases presenting symptoms of trouble that she runs across in her daily work. As a rule, however, she rarely sees anything but the most obvious need. Why should she? Competent work of this kind cannot naturally be expected of nurses whose training has not included mental nursing. If public health nurses are to be effective in mental hygiene work, training in a good mental hospital is a *sine qua non*.

For some reason, probably ignorance, the graduate of a general hospital has been a little inclined to minimise the advantages of special training for mental work. She is inclined, and perhaps justly to deny the right of the graduate of the special hospital to nurse cases for which she has not been trained, but not infrequently she is herself quite ready to undertake a difficult nervous or mental case, about the nursing of which as a matter of fact she knows nothing, feeling that she is doing well if she manages to "get along" with her patient, and all unconscious in her ignorance of what she is leaving undone. This point of view is changing with a greater knowledge of mental training schools, but it must change entirely if nurses are to succeed in this most difficult specialty of nursing. There is no more reason why a nurse untrained to mental work should be able to deal with a mental case, than why one without training in obstetrical work should be considered capable of taking a confinement case. For this reason, and because comparatively few public health nurses have received thorough mental training, as well as because the writer is a believer in specialisation, she feels that mental hygiene nursing should be undertaken by special nurses who are graduates of good mental hospitals.¹

¹ We do not here allude to the social worker who is doing mental hygiene work, or to the nurse who is attacking the problem from its purely social side.

These nurses may be employed by a hospital, and do their work in connection with its out-patient department and in following up its discharged patients, or, which would seem better, they may be a part of a regular visiting nurse staff. By the latter method their work would be correlated to the other public health nursing of the city, and a better system of supervision provided.

The nurse who takes up mental hygiene work must be prepared to look upon her specialty as covering a broad field, and must expect to lend her aid to all those of unsound mind. The term may be applied in its broadest sense to the helpless idiot or imbecile, the higher grades of the feeble-minded, the chronically insane, those suffering from recurrent mental disturbance, the alcoholic, the would-be suicide, the sufferer from general paresis, the so-called nervous, and those who may be otherwise normal but who present such marked peculiarities of temperament as to make family adjustment difficult. Her work will include the finding of patients and placing them under observation, the visiting and instruction of patients at the request and under the advice of private physicians and the assisting at clinics where she will bring to the doctors such additional information regarding home conditions as will aid them in both diagnosis and treatment. She will be called upon to help the families to secure hospital admission where necessary, and will also give such other assistance as the exigencies of the case require. She will visit under the direction of the hospital doctors paroled and discharged cases, she will study the various situations from her own particular angle, thus helping to create better public opinion, and she will keep such records as will prove helpful to other agencies. Let us look at these duties somewhat more in detail.

To find and bring under observation new cases two things are necessary: first, the nurse must be able to recognise mental disturbance when she sees it; and secondly, she

must have free clinics or some substitute for them, to which she can bring her patients when found.

In the finding of new patients the usual channels of information may be used. All individuals of marked peculiarity may be reported to her by the other nurses, by the charity organisation visitors or other philanthropic agencies, by physicians who do not themselves care to deal with the situation, or indeed by any one who recognises that a vague something is wrong in a household. The nurse's first duty on receiving such information should be a visit to the home, and in this first visit her special training is indispensable. The object of the visit is not to give general advice, but merely to ascertain whether or not some one in the family shows such symptoms of mental or nervous trouble as to make diagnosis of his case desirable, and if so to arrange that he see a doctor. In making inquiries, the nurse will need to exercise great tact and circumspection. It may be necessary for her to diagnose to the extent of deciding whether or not the reported case is really one requiring medical attention. Beyond this she must be careful not to go, and the requests of the family for an opinion must be met with the reply that only a doctor can give the desired information.

She must enter the house with an open mind, for such information as she has received may be quite misleading. Not infrequently the member of a family who complains of the peculiarity of a relative is the one who himself has the distorted point of view, and the nurse will find that the reported patient is not indeed the patient at all. On the first visit or visits, for more than one may be necessary, it will be well if possible to talk separately with both the patient and another member of his family, though the natural disinclination of the nervously ill to be talked about must be reckoned with, and every effort made to avoid antagonism at the beginning.

The nurse must be on the look-out for cases of arrested

development and prepare to find mental defectiveness where it has never been suspected. Many an incorrigible child has been cruelly punished in the vain effort of well-meaning parents to "beat sense into him," when as a matter of fact the poor little brain was incapable of getting sense, even by more scientific methods. Many a bright looking girl of twenty has been morally ruined because no one knew that she had but the intelligence of a child of ten with which to protect herself from the dangers of city life. There are few public health nurses, alas, who have not had personal knowledge of a feeble-minded mother of an appalling number of illegitimate children. Such a girl comes to my mind as I write, who at twenty-nine has had ten children, each with a different father. Maggie has a bright, rather attractive face and a strong, well-developed body, yet the Binet test, applied after the birth of her tenth baby, showed her to have the intelligence of a little girl of eleven. If at fifteen some one had recognised the poor child's undeveloped mind her history might have been a different one, and the city and a number of private agencies saved much unnecessary expenditure.

It is not only the defective child or young girl, however, who causes trouble. Every charity organisation has history records which read like the following: "In 1905, Mary Ann, then the mother of four children, was the despair of the social agencies of the city. For years, she maintained the semblance of a home, in wretched shacks usually approached through alleys. She lived a hunted sort of life, alternately abused or deserted by a brutal husband, foraging through alleys for food and begging indiscriminately. The representatives of various social agencies tried to apply to her the laws and theories designed for the adult head of a family; thus the truant officer would exhort her to keep the four children regularly at school with threats of prosecution if she failed; the charity worker would pay her rent and demand co-opera-

tion in the form of a well-kept home in return; the probation officer would call and revolted by the conditions of the home, threaten to 'take her children away if she did not take better care of them.' Mary Ann would clutch the last baby closer, and look out in a scared way, and occasionally when the ministrations of these well-intentioned agents grew too persistent, she would disappear with all her children for a period of several months."¹ It is unnecessary to follow poor Mary Ann's history through all its miserable details until she was finally brought into court on the charge of selling her young daughter to an Italian man. Had the record been dated 1915 instead of 1905 it is probable that it would read differently, for at some point in many similar histories we now find the entry "Binet test shows intelligence of a child of nine." How absurd to expect "co-operation" from a mother with the mind of a child of nine!

In dealing with the feeble-minded the nurse must be prepared for discouragement. There is sometimes a long interval between the recognition of a situation and the discovery and application of a remedy. We are learning that the mentally defective are incapable of adequate care of themselves or those dependent on them. How incapable, the Binet-Simon and other intelligence tests are able to tell us with more or less accuracy. It is generally conceded that the feeble-minded girl should be segregated for her own safety and in order that she may not have children. What to do with the family cared for or uncared for by the feeble-minded man or woman presents a more complicated problem. At least, the nurse can bring about the examination of such defectives in order that the agencies dealing with them may have the benefit of definite knowledge of their mental inability. It is to be

¹ Amelia Sears, "Problems which the Mentally Subnormal Adult presents to Social Workers." *Public Health Nurse Quarterly*. October, 1914.

hoped that with the more general and scientific examination of school children, and the awakened feeling of the whole community toward the question of the feeble-minded, more ample provision may in time be made for them.

In listening to the histories of patients there will, of course, be much chaff that must be blown away, before that which is pertinent to the situation can be gleaned, but the trained ear will be quick to take into account such characteristics as reticence, seclusiveness, stubbornness, fads about diet, brooding, sensitiveness and suspiciousness, when shown in connection with other oddities and strange behaviour.¹ These are often the danger signals displayed long before the occurrence of a break-down, in the form of mental disorder called dementia præcox or disorders closely related to it. Such patients are usually unable to make the more difficult adaptations of life, and the break-down is apt to come at the moment of unusual demand. As a rule, it comes unexpectedly, for the simple reason that there was no one to read the obvious signs.

Dr. August Hoch cites the following case in a pamphlet entitled, "Early Manifestations of Mental Disorder." It is of a predisposed girl who began to show mental symptoms when she became engaged but who was allowed to marry, thus precipitating a mental break-down. "The patient is a girl of twenty-two. She was not very bright at school; sometimes when the teacher asked her questions she gazed at her without answering. But on the whole she was not very peculiar, not decidedly unsociable. From the seventeenth year on, however, a change came over her, and she became more reticent and less sociable. Seven months before admission to a hospital she became acquainted with a man, is said to have become very much infatuated with him, and was engaged after a short acquaint-

¹ Dr. August Hoch, "Early Manifestations of Mental Disorders."

ance. Soon after this she began to show an indefinite fear, and, having lived away from home, she now returned to her parents' house. She soon developed fancies, thought her fiancé might come after her with a knife. She had crying spells without saying why, was morose, and asked her sister to chop her head off. In spite of this plain beginning of psychosis she was married some weeks before admission and very soon got much worse and developed a grave psychosis from which she will not recover." Dr. Hoch goes on to say that the definite symptoms which developed at the time of the patient's engagement should have served as a warning, for they were of such a nature as to show plainly that they were connected with a lack of adjustment to the engagement, and a psychiatrist would have realised that she was utterly incapable of the adaptation demanded of her by marriage.

As it is estimated that the dementia præcox cases represent nearly a quarter of all the cases admitted to mental hospitals, it will be seen that a large field of usefulness opens to the nurse who tries to bring such patients under early observation and treatment.

In addition to this class of cases, the nurse must be on the look-out for manifestations of the various forms of mania and melancholia. The symptoms of these diseases usually show an exaggeration of normal emotions, and this of itself tends to obscure the situation from the lay observer. Care in an early stage of these diseases will often save untold suffering to the patient, for by such care later and more serious developments may perhaps be avoided. Many unheeded signs will be found, if looked for, which indicate the trend of a mind which is silently contemplating suicide, and with no one class of patients has wise, kind and scientific treatment been more successful in an early stage. Even for cases of other types which cannot perhaps be cured, early recognition of the exact situa-

tion will often save the family from depending upon the unwise judgment of a patient whose impaired mental condition has not been suspected.

In addition to the early manifestations of what later develops into actual insanity, there are many forms of minor abnormalities which pass under the name of nervousness, and which, though imposing great hardship upon entire families, are allowed to go uncared for, especially among the poor and ignorant. The nurse should be prepared to obtain a diagnosis for all cases showing marked tendencies to moodiness, unwise enthusiasm, odd attachments, suspiciousness, exaggerated timidity or anxiety, unusual interest in religious questions, an unhealthy feeling towards matters of sex or other warped mental attitudes. That one or more of these tendencies exist in many normal people, is, of course, true, as it is also true that a man may be living a normal life with a weak heart. We should, however, think the man with cardiac trouble unwise if he failed to have his heart examined, or if, after examination, he failed to follow directions laid down by his physician. Similarly many a nervous patient might be leading a normal life under slight supervision, thus changing the whole aspect of the world for himself.

Among those ignorant of nervousness the nervous member of a family is apt to have become one of two things, a despot and a tyrant who rules with a rod of iron because his friends are afraid of the results of crossing him, or a pitifully misunderstood martyr who learns to feel himself so great a burden as to long for the release of death. In either case the real situation, which is primarily one of disease, is not being touched, and the family who gives in to every nervous or selfish whim in order to avoid friction, or the one whose harsh misunderstanding causes such misery, are alike helping to push the poor patient down the hill toward more serious trouble. The authoritative voice of the doctor, aided by the detailed information given him

by the nurse, is needed to help in each case to a right point of view. Often the first treatment for such patients lies in their temporary removal to another environment, and a vigorous training of their families, for an unmodified theory that a patient cannot control his nervousness, or that it is entirely within his control, is in either case fraught with danger to his welfare. As a matter of fact, there is enough truth in each theory to make the management of a nervous case one of the most difficult things in the world, but a wise sympathetic nurse working under the advice of a good physician can do wonders to change insupportable conditions.

The tragedies and broken lives brought about by nervous or mental illness in any of their forms can never be estimated, and in doing her work the nurse, as with tuberculosis, must learn so to guide her sympathies as to protect the normal while she is helping the diseased, for as a public health nurse her duty is no less to the well than to the sick. In spite of the fact that the "germ theory" does not apply to nervousness, there is nothing more contagious, and the selfish demands of the nervous sufferer, or the unhappiness or peculiarities of the mentally ill, should not be allowed so to dominate a family as to cause the break-down of others. From the patient's point of view, too, it is a recognised fact that strangers, even untrained strangers, are often better nurses for the nervous than the most devoted friend or member of the family, a fact difficult to be grasped by the uninformed.

In bringing undiagnosed cases to a psychiatric clinic the nurse will, of course, observe the usual rules of professional etiquette where there is a family physician. Because the finding of incipient cases of mental trouble is a new field of work, and because the mental hygiene nurse is a comparatively new development, she will have her way to make, and must expect to meet the same obstacles to progress that have been met by all the other types of

public health nurses in the early days of their work. She will do well to make a study of the methods which have been successful in the other special branches of public health nursing, for the same principles will apply to many of her own difficulties.

As in tuberculosis or infant welfare nursing good work is impossible without the free clinic, so in mental hygiene nursing some place to which the early case may be brought for diagnosis and continued supervision is a necessity. If no psychiatric clinic exists, some temporary arrangement can be made by which the need for better or more permanent arrangements may be demonstrated. It has been proved in a number of places that with a little assistance patients are glad to avail themselves of the advantages of psychiatric clinics, and, once the need for help is felt by the patient himself, half the battle is won. If it were possible to arrange for a number of small well-served clinics it would probably be found that the people of the neighbourhood would more readily make use of them. These, however, should be under one general management, or at least should work in the closest co-operation, in order that patients should not wander from one to another as the spirit moves them.

As regards the nurse's duties at the clinic, they will consist: first, in helping the patients to feel at home and at ease, in order that they may talk freely to the doctor, and will also be encouraged to come again; and secondly, in placing before the physician all the information gleaned from the home visiting. New patients will be much more apt to come if they are sure of finding a familiar friend who will help them through the ordeal.

In her work in the homes the nurse will, of course, work as do all other public health nurses under the advice of the physician in charge of the case, and here all her powers of adaptability will be required. It is probable that the majority of her cases will be under the care of alienists or

neurologists, in which case her own training in mental nursing will be recognised, and her path will be an easy one as far as her relation to the doctor goes. Her work will follow certain recognised lines, its possibilities and limitations will be understood and the impossible will not be expected of her. On the other hand her capabilities as a trained, and therefore scientific, worker will be admitted, and she will be given a free hand within the limitations of her own sphere of work. The minute, however, that she steps outside the little group of alienists and nervous specialists her path is likely to become a more difficult one. She must not despair if her usefulness seems curtailed by a lack of understanding of her functions, but remember that history is but repeating itself in her own experience. Every public health nurse has met and successfully dealt with a misunderstanding of her work when her particular branch of nursing was new.

As regards the nurse's co-operative work for her patients, it will not greatly differ from such work in the other fields of public health work. She will, of course, make herself thoroughly conversant with the various agencies on which she is likely to call and will understand the methods employed by the hospitals and institutions in admitting patients, as well as the laws of her state regarding commitment. In working with the hospitals, she must not forget that it is her privilege to help them in their work for the mentally ill, as well as to ask their aid in her own.

The systematic visiting of paroled and discharged patients has been a form of mental hygiene work which has everywhere been attended with good results. The leap from the protected life of a mental hospital to even the most desirable normal environment is one that usually taxes the patient's powers of adaptability to the uttermost, and, as we know, the home environment is too often quite the reverse of desirable. There is as little common sense in returning a newly recovered mental patient to the ex-

act conditions which caused his break-down, as in returning a cured baby to the care of an uninstructed mother, who in her ignorance instantly resumes the injudicious feeding which so nearly caused its death. A call at the home of the patient before he leaves the hospital will be time well spent, for much can be done to prepare the way for his return to a healthy atmosphere.

A case cited by Dr. Gregory, resident alienist at Bellevue Hospital, is doubtless more or less typical of many others. "I can never forget a young man, twenty-two years of age, who came to the hospital in tears and asked to be sent back to a state hospital from which he had been discharged recovered, three months previously. He was on the verge of break-down, and stated that if he remained at home any longer he felt that he would become mentally ill. He stated that on his return from the state hospital his every action would be misinterpreted by the family as indicative of a return of his mental trouble. That if he came home late at night, or whistled, or sang, or had any little disagreement with his young sister, his family would at once regard him suspiciously. The case was referred to a social worker who found a home for him away from the family for a short period, and after correcting the wrong point of view of the family he returned to his home and has been happy, contented and successful ever since."¹

Of course, the object of all treatment is the return of the patient to his normal environment in such a condition that he will be able to meet without assistance the usual difficulties with which all men and women are obliged to cope in the ordinary routine of daily life. There must, however, be an intermediate stage between the complete protection of the hospital ward and a wholly normal and unprotected life. This the nurse must try to obtain for him, and his family and friends must expect to lend their

¹ Dr. M. S. Gregory, "Social Service in Preventing Mental Break-downs." Report Mental Hygiene Conference, 1912.

aid for a time, quietly and simply, without apparent anxiety, until at last he can stand alone, normal again in his power of mental adjustment.

The future of mental hygiene work for public health nurses cannot be predicted. Dr. M. S. Gregory, Resident Alienist at Bellevue Hospital, sounded a significant note at the Mental Hygiene Congress in New York. He said, "Of course certain forms of mental trouble should be treated in the state hospital. However, the more I think of the matter, and as my experience increases, the more I realise that for some classes of mental diseases hospital treatment may not be the best kind of treatment. These patients become, so to speak, institutionalised. The quiet and routine life of an institution tends to the development of unhealthy physical and mental habits, and as life in an institution is so different from the outside world, they are unable to adjust themselves after their discharge. It would be more logical and profitable to treat such patients under normal and natural surroundings at home. I think the old Scotch method, as well as that applied in Gheel, Belgium, with added intelligent social service supervision, is preferable to state hospital care in certain types of mental disease."¹

If an increasing number of patients are in the future to be cared for outside of institutions, mental hygiene nursing as done by the public health nurse is likely to grow apace.

The preventability of mental disturbance is naturally a question of great interest to all who are giving their time to mental hygiene work. That heredity plays an important part is unquestionable.² Exactly what part, has yet to be determined. That alcohol is responsible for certain

¹ Dr. M. S. Gregory, "Social Service in Preventing Mental Break-downs." Report Mental Hygiene Conference, 1912.

² Roughly about two-thirds of all cases admitted to insane hospitals occur on an hereditary basis. Dr. A. J. Rosanoff, "Heredity in Relation to Insanity and Eugenics." Report of Mental Hygiene Congress, 1912.

forms of mental disease is also unquestioned, but to what extent its excessive use is due to an already weakened mental balance is hard to say as so many chronic alcoholic patients are found to be psychopathic in one form or another. Syphilis again is held responsible for no small percentage of some mental disorders. Indeed it is considered to be the only indispensable cause of general paresis, but again only a small percentage of syphilitics succumb to general paresis, so that other contributing causes must be sought.

The practical application of the, as yet but partially understood science of eugenics, the suppression of alcohol, and the elimination of vice with its accompanying diseases, are large problems, unsolvable in a day, or without the backing of a thoroughly awakened public sentiment. If the nurse in her work feels bitterly the waste of human intelligence, due to the mating of the unfit, or to indulgences which wreck the mind, she must gird herself with the type of courage which, while willing to work unremittingly for a cause, sees plainly the limitations of her own usefulness and is so content to wait hopefully for results. Mental hygiene nursing should not be thought of as discouraging. On the contrary, the newer forms of treatment are constantly adding new hopefulness to the work, and there is no field of a nurse's usefulness in which a consciousness of worth-while effort may be more keenly felt. If a mental hygiene nurse can bring individual help to the mentally ill, if by her home visiting she can assist the doctors in their work, and if her influence throughout her community makes for a simpler and saner attitude toward mental and nervous troubles, she will have done her small part toward bringing about better days for a group of patients whose need of her is unquestionable.

CHAPTER V

INDUSTRIAL NURSING

ALTHOUGH the first industrial nurse was employed nearly twenty years ago, industrial nursing in its present development may be said to be one of the newest forms of public health nursing and is as yet less standardised and less supervised than other branches of the work.

It is difficult to state authoritatively when and where the first industrial nursing was started, but it seems safe to assign the honour to the firm of John Wanamaker, which employed a nurse in its New York store in 1897. One other store, that of Frederick Loeser's, Brooklyn, also dates its industrial nursing work from the last century (1899), while factory nursing seems to have been started at the Plymouth Cordage works, Plymouth, Massachusetts, in 1901, and at the Cash Register Works, Dayton, Ohio, in the same year. The Hotel Astor, New York, was the first hotel to employ a nurse in 1905.

Industrial welfare work in any given industry may be carried on in one of three ways; by a social worker who will naturally do no nursing; by a nurse whose primary function is nursing, but who is expected to do social work as well; or by both a social worker and a nurse who will each serve in the field for which she has been trained. It will thus be seen that industrial welfare work does not always include nursing, though the term is often used to describe the work of a nurse in an industrial establishment. We will not in the present chapter consider industrial welfare work as done by the social worker, because interesting as is that field of usefulness it does

not come within the scope of a book on nursing. Even looked at solely from the standpoint of the nurse, the subject is one of which it is most difficult to write helpfully, because the term, industrial nursing, covers so broad a field and because the industrial nurse works under so many and such diverse conditions, each situation requiring totally different methods and presenting totally different problems.

Nurses are now to be found in factories, in stores, both wholesale and retail, in large hotels, in the office buildings of telephone, insurance or other business companies, in mining villages, indeed almost everywhere where men or women are employed in large numbers. Methods of administration differ almost as widely as do the types of work done. If the nurse works directly for the company or firm employing her she may be guided by them in every detail of her work, or she may be permitted an entirely free hand in its arrangement. Because of this absence of fixed standards, the method, common in a number of cities of employing nurses who belong to the staff of a visiting nurse association has much to commend it. Continuity of work is thus secured, high standards are maintained, expert supervision provided, and perhaps most important of all, the employment of non-graduate nurses is avoided. Under such an arrangement the nurse usually wears the uniform of her association and remains on its pay roll, the company making monthly or weekly payments to the association for her services. For small establishments employing few workers where the full time of a nurse is not required, part time may be arranged for in this way to advantage.

The problem of the ultimate financial responsibility for the medical and nursing care of the small wage earner is occupying the minds of many reformers in this and other countries, but in America certainly it is, as yet, far from solution. Where people have become accustomed to

sick benefit funds by means of which they themselves bear the expense of illness, there is a tendency to feel that service not so paid for is likely to be less satisfactory. As a rule, however, employers have found that through such funds preventive work is never done, because the importance of preventive measures is rarely sufficiently understood. Undoubtedly the new health insurance laws which are pending in a number of states will, if passed, play an important part in the future development of all the branches of public health nursing.

If a nurse does not belong to the staff of a visiting nurse association, she will need to bear constantly in mind the danger to all unsupervised work of deterioration, and must set herself to combat this tendency by continually measuring the quality of her work by the standard of that of other public health nurses. Without the double stimulus of the approbation and criticism, which is a part of supervision, it may not be easy for her to judge her own efforts fairly, but she must try on the one hand to avoid undue discouragement, and on the other an easy satisfaction, which is death to better things. She must remember that it is not enough to satisfy her employers, who are in all probability unfamiliar with the finer technicalities of public health nursing. Real and lasting success can only be attained by the nurse whose work conforms to the highest standards of her own profession.

The industrial nurse, though she may be a pioneer, usually begins her work under favourable conditions, for the very fact that a firm or company has so desired her services as to be willing to pay for them implies a sympathetic attitude. She rarely therefore starts without the moral support of the management itself, and this she must remember if at first she is somewhat handicapped by the attitude of foremen, or others, who do not understand why she is there.

Many motives usually enter into every action, but though a few employers may have been influenced in the establishment of their welfare departments by a desire to escape criticism or by the thought of advertisement, it is safe to assign to the great majority two chief motives, a genuine desire to better the conditions of their employés and a recognition of the principle that efficiency of service is secured by the health of the employé as much as by the good condition of the machinery employed. It goes without saying that where improper wages are paid and working conditions are unnecessarily bad, a department established to benefit the employé is an anomaly, and will be built on too insecure a foundation to accomplish permanent good. Without the three requisites of industrial well-being, steady work, a living wage and healthful working conditions, any industrial nurse will have an uphill road to travel, but even under the poorest conditions let her honestly do her best before she decides that her work is useless.

Perhaps, the most important requisite for the industrial nurse is wisdom, therefore we would advise the very young woman to delay entering this particular field of work until experience has somewhat ripened her judgment. She will need to steer a very careful course between the maintenance of a sympathetic and watchful attitude toward the employés and one which will partake of the nature of coddling.

An intelligent nurse will naturally familiarise herself with methods of industrial welfare work as carried on elsewhere, and it will also be well for her to make some study of the conditions governing the special industry with which she is connected. It seems almost hopeless to suggest that she should try to understand the complex problems of general industrial conditions. The whole labour question is so involved, and so many side issues affect the problems, that there is danger a little reading will

only prove confusing. The thoughtful nurse, nevertheless, should know enough to be aware that she is in touch with many more forces than meet her eye in her immediate work. If she is of the type to whom study of this kind is enjoyable, she may add greatly to the interest of her work by well-selected reading, but let her beware of forming unripe opinions or jumping to hasty conclusions after having read half a dozen books. Any reading should be done with a view to getting a glimpse of the various aspects of the whole subject, and the books selected, therefore, should not deal with a single line of argument.

Closely allied to the health problems of industrial workers is much of the labour legislation continually being enacted or which is under consideration; that, for instance, of health insurance, whereby, the employer, the employé and the state share in varying proportions the expense of illness. As the provision for nursing service forms part of the scheme, industrial nurses will naturally be interested in the progress of such legislation in their own and other states.

One of the most valuable assets of a nurse engaged in such work is her power to interpret, simply and almost unconsciously, the employer to the employé and vice versa. This she will not be able to do unless she really sympathetically understands the attitude of each, and to the acquisition of this understanding she must apply every effort. She will, of course, form her independent opinion on a number of points, but she must under all circumstances maintain an unswerving loyalty to the company or firm which employs her, no matter how great her temptation may be to show her disapprobation of conditions or methods. If, after due trial, she finds that her ways and those of her employer are too diverse to admit of a common meeting ground of mutual understanding, she would better seek work elsewhere, for she quite evidently has not found her niche. She must remember that her power to sow the

seeds of discontent is just as potent as is her power to disseminate a spirit of loyalty and appreciation. An industrial nurse is often described as a neutral and it should be a true description, but the best neutrality does not mean a policy merely of hands off, but the friendly and understanding attitude toward both sides that will help to bridge chasms often formed by mere ignorance of reasons and motives.

Different methods of work are necessary under different conditions. As a rule the nurse working in the factory will combine office hours and a general oversight of health conditions with home visiting, the family as well as the employé himself being cared for at the expense of the company. Work in stores usually implies less home visiting, sometimes none at all. In mining villages, on the contrary, home visiting may take all the time of the nurse. In hotels, a nurse has to guard against encroachment on her time by guests of the house, thereby reducing her usefulness to the employés.

The question of professional etiquette is often a confusing one for the industrial nurse because of the varying arrangements made for medical service. Some companies have their own doctors who are present at daily clinics, and to whom the nurse has free access at all times. Others employ doctors for part time work, and still others make special arrangements for the services of physicians when needed. Varying methods also pertain in regard to the degree of responsibility for health conditions assumed by different employers. Some companies which require a physical examination of all employés do so merely for the purpose of the exclusion of the unfit. Others offer very complete examinations and re-examinations to all their employés, results being recorded in such a way as to make the information effective for the prevention of individual illness.

Whatever the arrangements for medical care may be, the

nurse must see that her own duties as a nurse are clearly defined, and must guard against the assumption of undue responsibility. There is no reason why an industrial nurse should carry any responsibility not usually assumed by other public health nurses. Temptations to diagnose and prescribe abound, but they must be withstood, and if the prescribing of simple remedies such as cathartics, etc., is expected of the nurse, a very clear understanding with the doctor must be arrived at as to the exact limitation of her responsibility for such services. She must also make herself conversant with the company's wishes in regard to the demand that may be made on the time of the company physician. In some instances arrangements are made for an unlimited call upon his services; in others employés are expected to consult family physicians except in emergency.

The duties of an industrial nurse may, perhaps, be broadly divided into three groups: the care and advice bestowed upon individual employés at the plant, her responsibility for sanitary and hygienic conditions, and her home visiting.

The usefulness of a new nurse will be greatly increased if she is permitted to acquaint herself thoroughly with the working conditions of those whom she has come to serve. A nurse starting industrial nursing in Chicago attempted no nursing for the first week, but used the time to make an inspection of the huge plant under the guidance of a man long in the employ of the company who was assigned to the task of taking her about. In this way she gained at the very beginning a general impression of conditions at the works, which could later be amplified, and also had the opportunity of meeting and talking with the superintendents of the various departments.¹ The nurse who has not the privilege of going into the places where the em-

¹ Eva S. Andersen, "The Work of an Industrial Visiting Nurse," *Public Health Nurse Quarterly*, April, 1913.

ployés are actually engaged must naturally work less intelligently, and consequently, less usefully.

The wise nurse will be content to proceed slowly at first, bringing to the company only well-considered plans and suggestions, and she must try to add to her social attitude of mind an outlook on the business aspect of the various situations, for there must be no taint of sentimentality or a purely one-sided point of view about her work. A factory, business house, or hotel is not an institution for the care of the sick, and though due provision should be made for the protection of health, the nurse must recognise all the other questions involved, and not expect that health and the welfare of the sick will be the primary concern of the management, as is the case in hospitals or other institutions which are maintained for that purpose alone.

To attain her greatest usefulness a nurse should be easily accessible, and her accessibility will depend on a number of factors. If her own personality inspires confidence the employés will be drawn to her, but unless their coming is made easy, she will only get the more obvious cases. The attitude of superintendents and foremen who refer cases to her is important, as is also the question of whether employés are permitted to come to her in time not their own. Nothing, however, is more important than the value placed upon her work by the employés themselves. Many men feel that attention to slight injuries or the reporting of seemingly unimportant symptoms stamp the men requiring such attention as unmanly. Just here, the nurse will require almost inspired insight and knowledge of character. It is not unmanly to protect a slight injury from infection, or this would not be so rigorously insisted upon in the army, or to try to discover the cause of a pain which may be an early symptom of a serious trouble. On the other hand every one is familiar with the type of young person to whom nothing is so delightful as a long

discussion of their mental, moral or physical selves. This type of man or woman, boy or girl, the nurse must train herself to recognise, as she must also recognise the employés who too readily avail themselves of the opportunity to break the routine of duty by a trip to the nurse's office, or an hour in the rest room. Where piece-work is done, there will be less of this, but an industrial nurse must bear constantly in mind the money value of time during working hours and must assist both the company and the workers to avoid waste.

In all her dealings with employés the nurse should try to work through prescribed channels. If foremen or floor-walkers are expected to send the employés to her, she will effect a much stronger organisation by educating them to do so, than by becoming discouraged over a few failures, and attempting irregular methods of securing patients. If after an honest trial she finds that any given method fails to work, let her set about to change it by an appeal to the right authority.

Much of the nurse's office time will be spent on personal advice as to healthful ways of living outside of working hours, and she must not fail to enter into such details with those coming to her for help. The girl who asks for a pill to cure indigestion often needs in reality a long course of instruction on proper methods of feeding before she can be persuaded to replace the ice-cream soda taken after she arrives at the store by a suitable breakfast eaten at home. Behind the nervousness which brings another girl to the office may lie a whole tragedy of home difficulty, or perhaps merely a love of gaiety indulged in at the expense of necessary sleep. An understanding of these individual situations, and a little wholesome advice as to such simple things, as food, sleep, recreation, or the way of spending a vacation, will often be enough to tip the scale to the side of health. More and more are public health nurses learning that ignorance and carelessness weigh just as heavily

as poverty on the lives of thousands of people, bearing them down to sickness and ruined constitutions.

Because an industrial nurse's work is apt to be new to those by whom she is employed, she is tempted to yield to the temptation to make much of the more striking elements in her work, laying insufficient stress on the equally valuable, but less dramatic preventive efforts on which so much of her time is rightly spent. Her professional helpfulness in giving first aid to the injured, though, perhaps most effective in demonstrating her ability to command a difficult situation, or possibly even to save a life, is no more valuable than the time she spends so prosaically in persuading the men to take a few simple precautions for the care of their health or the avoidance of accident. There is much to tell of the critical case of pneumonia nursed back to health by the skill of the nurse, and little to tell of the incipient cold discovered and cared for before the lungs were affected, but every public health nurse is too well versed in the doctrine of prevention to need any reminder of its importance. We would merely, therefore, urge that she make this point of view equally clear to those among whom she works.

The detection of cases of contagion is a part of her responsibility for the health of the workers collectively and for the welfare of the individual. An industrial nurse should be constantly on the look-out for early symptoms of every form of contagious disease, and should be able to detect and bring to the doctor's attention cases of tuberculosis while there is yet hope for the patient's recovery, and before others have had time to become infected through his carelessness. Great changes have taken place in the minds of students of public health as to how contagion is carried. It has been pointed out by such pioneers in modern public health work as Dr. Charles V. Chapin that many of the terrors of earlier days, leaky plumbing, soiled clothing, foul air, garbage, bad smells, etc., though cer-

tainly undesirable from every point of view, are quite innocent as means of spreading contagion, which in reality is carried only through direct contact with infected material thrown off by infected individuals. If the nurse is a graduate of some years standing she will do well to make herself familiar with these more modern theories before attempting work which deals with large groups of people necessarily thrown together for many hours each day. She should also take time to familiarise herself with the laws of her state which affect industrial conditions, the prescribed working hours for women, the minimum number of cubic feet of air required per person, the laws governing the work of children, etc.

As has been aptly said employés must of necessity often be thought of collectively. It is the nurse's duty and privilege to think of them individually. Through effecting a change of employment for those who are handicapped by some physical disability which makes certain forms of work undesirable she can often be extremely helpful. To do this the nurse should first be sure of her facts, both in regard to the patient's condition and the work which he is doing. Usually there will be little difficulty if the matter is taken up in the right way, and if the nurse has succeeded in establishing a reputation for good sense as well as a kind heart.

If there is no social welfare worker, a number of responsibilities will devolve upon the nurse which would otherwise be out of her province. These responsibilities are of two types, the solving of individual social problems and the arrangement of matters which affect the general welfare of the workers. The former, the individual problems, will not differ from those encountered by other public health nurses and must be dealt with in the same way by personal advice and by co-operation with other agencies. To attain her greatest usefulness, therefore, an industrial nurse must be supplied not only with wisdom and good

judgment, but with a thorough working knowledge of the resources of her city. A young girl may need advice as to a boarding place, a boy an introduction to a boys' club, a man assistance in securing reliable legal aid, or an old woman admission to a home, and with such situations a nurse will be powerless to deal except through intelligent co-operation.

The second responsibility, that of advising upon matters affecting the welfare or comfort of the employés at their work is not a simple one, and before offering any suggestions the nurse should make a thoughtful study of the situation. If she works in collaboration with a social welfare worker, she will probably have to deal only with conditions very obviously affecting questions of health. If she works alone, a much wider field of responsibility will be hers. If the changes she contemplates are many, she will be wise to make her requests strictly in the order of their importance, possessing her soul in patience regarding all non-essentials.

For her own immediate work she will need a suitable office equipped with the proper necessities, and so situated as to make privacy possible.¹ She will need a simple but adequate system of records, and a workable method of bringing her services to all of the employés who need her, either for actual care or for instruction and advice. Farther afield, she should try to secure for the workers conditions conclusive to health and safety, proper systems of heating, lighting, and ventilation, clean and decent sanitary arrangements, an accessible supply of pure drinking water, safety devices for protection from accident, dust or dangerous fumes, suitable rest rooms, etc. She may go farther and use her influence toward the establishment of comfortable lunch rooms where subsidiary hot meals can

¹ Many concerns in addition to a nurse's office provide a hospital room for emergency treatment, while some maintain small hospitals for the use of employés.

be served at low prices and she may interest herself in the installation of good locker rooms, shower baths, and other conveniences which will add to the comfort of the workers. In all such efforts the nurse must be reasonable. If she is working in an old building she must recognise the limitations involved, and must be prepared to meet the management fully half way in improvising and making the best of not wholly satisfactory arrangements. Sometimes a seed may be sown which will not grow to maturity in her day, but which will have its effect on future building operations.

When the employ  s or operators are properly housed, when the rooms or departments in which they work are properly cleaned, heated, lighted and ventilated, when safety devices are in use, when wages and hours of work are fair, when pleasant rest rooms and lunch rooms exist, when doctors and nurses are employed to teach hygiene and care for cases of illness or accident, it is a question in the minds of many employers how much farther it is desirable to carry industrial social welfare work. Libraries, gymnasiums, tennis courts, free lunch rooms, club houses, etc., all form part of the scheme of social service or welfare work as carried on by a number of business enterprises, factories, stores, and insurance companies. Certainly the reports of such activities form pleasant reading, but the industrial nurse must not be carried away by them and feel her lot a hard one if these things are not regarded favourably by those for whom she works. Let her fix her eyes steadily on essentials, and be content to work slowly toward her desired ends.

A certain amount of time will always have to be spent in educating the people to a proper use of the health arrangements made for them. Sanitary cuspidors are of no value, unless they are used. Nothing has been accomplished by the installation of a pure water supply if a handy nearby tap of bad water is used instead. Clean-

liness cannot be maintained unless all do their part toward its maintenance. Of course certain rules can be enforced, but far more will be accomplished by instruction than will ever be brought about by uncomprehended regulations, and it is a recognised fact that the constant presence of danger breeds a contempt that finds its expression in carelessness. Time is well spent by the nurse who succeeds in inducing men who work at such trades as dipping or grinding to wear glasses for the protection of their eyes, or in making popular the use of special shoes for moulders who are so often incapacitated by burned feet. If her patience sometimes becomes exhausted by the lack of interest displayed in such things, she must remember that comprehension of the more subtle laws of cause and effect implies a considerable degree of intelligence.

Home visiting is by no means universal in industrial nursing, but by those nurses by whom it is done it is usually felt to be of vital importance if really effective work is to be accomplished. Home nursing will often, of course, imply the employment of more than one nurse, in which case the nurses may alternate in working in the homes and at the plant, thus familiarising themselves with all the problems involved. The home visiting of the industrial nurse differs only from that of other visiting nurses in that her ministrations are confined to the employés of the firm or company for which she works and their families. If a man changes his work while sickness is in his family, and the nurse is consequently obliged to withdraw her services, it is her duty to see that the case is duly turned over to the visiting nurse association of the city, if such exists, or that the best provision possible is made for future care. Through her home visiting it is in the nurse's power to greatly strengthen the bond between the employer and the employés. The announcement on her first visit that she has been sent by the company to give her aid rarely fails to give genuine pleasure. Many industrial nurses receive

a daily list of absentees, on whom a routine visit of inquiry is made. It rests with the nurse to make these visits acceptable and to avoid all unpleasant semblance of having been sent to spy out the land, not a difficult matter unless she is signally lacking in tact.

The question of relief will inevitably arise. Three forms of relief organisations are to be found in industrial work; benefit organisations maintained entirely by the employés, organisations maintained by employers, and organisations mutually maintained by both employés and employers. Occasionally, a small sum of money is placed in the nurse's hands for her personal use among the sick. She may find this convenient, but she should be very chary of all personal administration of relief funds, and for any permanent financial relief apply to the proper sources for assistance.

In industrial nursing, as in every other kind of public health work, the problem of records is still an unsolved one. In most industrial concerns a careful record is kept of all accidents or injuries, no matter how trivial, but this often constitutes the sum total of recorded information. It is important that the nurse should be able to render a suitable report of the use of her own time. For statistical purposes, therefore, she should know the number and type of her home visits, and also of all office calls made upon her, either for advice or nursing care.

Where regular routine examinations and re-examinations of the employés are made, records will, of course, be kept for reference in the maintenance of individual health, and should also be available for study of the health condition of the workers as a whole. Even when single examinations are made by company doctors, merely with a view to the exclusion of those below a minimum standard, (such examinations will be more usual in states where workmen's compensation acts increase the employer's liability for accidents) the information gained respecting the

condition of accepted candidates is too valuable to be thrown away.

Some welfare departments deprecate the use of records except for lists (without names) of the number of treatments given, on the ground that the employés are less apt to consult the nurse if they feel that a record is kept of each trivial ailment. In the light of the experience of other welfare workers this would appear to be a mistaken point of view, for there seems no reason why the value of recorded information cannot be made plain, and its usefulness explained, if the effort is made. It goes without saying that an assurance of the wholly confidential nature of the records must be given and no pains spared to secure complete privacy.

Without a good record system a new nurse starts her work where her predecessor began, not where she has ended, gaining nothing from past experience. Also the acquisition of the type of knowledge which comes from comparison of statistics would be impossible. Comparison of the health of employés working in different departments, or under certain conditions, the amount of illness during certain years, or before and after certain experimental changes, are most helpful in gaining an understanding of industrial health problems, as is also a study through comparative data of speed strain and the number of hours at which a girl can be employed at given kinds of work without impairment of health. Such studies are of real value and will be facilitated by records kept by the nurse. We would, therefore, advise a carefully planned system of record cards which will give the desired information in the simplest form and which will serve the double purpose of facilitating the care of the individual employé and of furnishing data for scientific study of industrial health problems. If the trade at which the employés work is a so-called dangerous one, the card should be so arranged as to give special information on the subject.

Granted a nurse with the right training and personality, backed by the intelligent co-operation of her employers, and aided by a record system devised to further constructive work, what may we expect an industrial nurse to accomplish for the company and for those employed by them?

It has been shown that industrial nurses have actually increased the working time of the individual employé by means of instruction which prevents illness, by advice which leads to the correction of physical defects, by the care of minor ailments which will permit those suffering from them to remain at their work, by the prevention of the spread of contagion, by looking up absentees, and sometimes, by the home care of members of the family whose illness has kept them at home, by insistence on the observance of the simple rules of hygiene and of suitable precautions in the dangerous trades, and by shortening the periods of actual illness by first aid assistance or by skilled nursing care. An interesting argument showing the cost value of "Constancy of Force," and also proving that the employer loses more than the workman when the latter is laid off, is used by Mr. Arthur H. Young of the Department of Labour and Safety of the Illinois Steel Company. He quotes from a paper circulated by the National Council for Industrial Safety, summarising the discussion as follows:

"From the total amount of all sales for the past year deduct the amount of the Pay Roll and divide the remainder by the average number of operatives. You will thus arrive at the amount of sales each man was responsible for as a worker in the company. In general, it will be found that this amount approximates \$1,000 per year per man which is equivalent to forty cents or fifty cents per hour per man, whereas the average wage per hour per man is twenty cents and twenty-five cents. Therefore when a regular worker lays off, not

only does he lose his regular wage, but the concern loses twice as much as he, for that sum which he would earn for the company must go to meet the interest on all fixed charges, and to create dividends. The firm must incur outlays to educate a new man to bring his production to par with that of the absent man, and during this period the concern loses all of its interest on that part of its work which the absent man took care of while on duty.”¹ If constancy of force is of such value to the employer, steadiness of work is of no less value to the employé, hence the usefulness of the nurse who increases both.

In considering the trend of industrial welfare work, a question naturally arises as to the attitude of the Trade Unions toward it. It might, perhaps, be described as one of watchful waiting. Not unnaturally, the unions fear the effects of slight reforms which will serve as a cloak to hide the abuses of long hours or low wages, but J. M. Sullivan of the Typographical Union, and a member of the Federations Public Ownership Commission, in speaking to the Home Economics Club, Teachers’ College, Columbia University, upon the Trade Unions’ attitude toward welfare work, opened his address by saying, “The Trades Unionists are observing sympathetically the National Civic Federation’s Welfare Department and its work is upheld by those who understand it.”²

The industrial nurse still has her way to make among both the employers and the employed. The former do not always recognise her need and for the latter the intangible value of health protection is always somewhat remote, unless it is first brought home in some very practical form. Her work, however, is so simple and sane, and her service so evident, that her establishment on a permanent basis is

¹ Arthur H. Young, “Industrial Welfare Nursing.” *Public Health Nurse Quarterly*, July, 1914.

² J. W. Sullivan, “The Trade Unions’ Attitude Towards Welfare Work.”

sure to follow her experimental introduction in any new field. For the very reason that industrial nursing is as yet so little standardised, the present day industrial nurse has it in her power to create what standards she will. What industrial nursing is likely to become is largely in her hands. The work is already being retarded through the employment by many firms of untrained women. It is for the graduate industrial nurse to so prove her value, that as general medical inspection of employées becomes part of state legislation, she will be found an indispensable part of all systems involving better provision for the health of the industrial worker.

CHAPTER VI

MEDICAL SOCIAL SERVICE

THE nurse who takes up medical social service work differs from other public health nurses, in that she deliberately enters another profession, and in doing so she will do well to consider carefully certain aspects of the situation. In all other branches of public health nursing the worker is chosen because her nurse's training is of such paramount importance that her other attributes are secondary to it. In other words, without such training she would not be considered as a public health nurse. In medical social work, her nurse's training, though most valuable, and in the opinion of many indispensable, becomes at the same time almost worthless, unless it is supplemented by a thorough working knowledge of the fundamental principles of modern social work. This cannot be obtained within the walls of a hospital, or lightly picked up in the daily routine of nursing, and this she must recognise if she expects to compete successfully with well-trained social workers on their own ground. So arduous and intensive is the training of a nurse, that as a rule, during her years of hospital life, she has little time to think of things not directly connected with her work in the wards, and as she somewhat breathlessly emerges from her training, this very lack of outside knowledge, not unnaturally leads her to think that she is capable of attempting any work connected with the care of the sick. She does not realise that social work, the diagnosis and treatment of those who need social readjustment, requires specialised training if it is to be well done.

If she is very inexperienced, she may hope to bring help to the needy by an unconsidered gift of money which will buy the immediately required necessity; if she is experienced enough to know that the emergency need of money is usually but a symptom of a more deep-seated and complicated trouble which must be sought and found, she is still, in all probability, in ignorance of the more complex aspects of the question.

In addition to this natural ignorance, her nurse's training tends to have developed in her certain attitudes of mind which must be altered by another type of mental training if she is to be a valuable social worker. The very strength of a nurse's power often lies in her singleness of vision. The fact that her patient occupies the centre of her stage, and that all else is seen as it affects him, makes the members of his family hardly exist for her except as they weary or refresh him during visiting hours, while his relation to the larger community in which he lives has no meaning for her whatever. Also, as we have said elsewhere, the necessary restriction placed on personal initiative during a hospital training develops in the average nurse an attitude of unquestioning acquiescence, which though perhaps a most valuable foundation, requires a superstructure of training in independent thinking to fit her for social work. Therefore we would say to the nurse desiring to undertake medical social service work, do not bring discredit on the profession which by years of hard work you fitted yourself to honour, by attempting to enter another without a proper apprenticeship in that.

Training in social work is now not difficult of attainment. There are good schools of philanthropy in a number of cities; the post-graduate schools for public health nursing offer specialised courses; certain hospitals admit graduate nurses as students in their social service departments; and failing these advantages, some already well-

established hospital social service departments are willing to take inexperienced workers to fill subordinate positions under careful supervision until experience is gained. Since a nurse's training is by most hospital social workers considered so valuable an asset in medical social service, it is to be hoped that nurses will not forego this opportunity of usefulness because of an unwillingness to spend time and money in fitting themselves to do it well.

Like almost all modern philanthropic work, medical social service has sprung into existence to fill a modern need. The old time family physician, driving about from house to house, needed no social worker to assist him. His patients and his patients' families were so well-known to him that there was no danger of his ordering the impossible, because his advice was founded on an intimate knowledge of family conditions financial and otherwise. All this has been greatly changed by the growth and increasing popularity of the great hospital, with its attendant out-patient department, where the individuality of the patient is necessarily somewhat lost and where his disease becomes the most important thing about him. His family, his home, his social circumstances, his personal character, and his financial affairs, though all really important factors in the consideration of his health, are so forced into the background that from the standpoint of the busy doctors and nurses doing their best for his physical welfare, he might as well be a mere body descended from the planet Mars for purposes of medical treatment, and after recovery instantly translated back to that unknown world. The frequent return to the wards of patients suffering with the very difficulties of which they had once been cured, forced upon the doctors a recognition of the fact that more than hospital care was needed to establish permanent health. In the out-patient departments failures were even more apparent, for there, home conditions exert a still more powerful influence. In

considering economy of effort it is quite evident that a doctor who, after a painstaking diagnosis gives advice which is not followed, has made poor use of his time as far as that particular patient is concerned.

In the United States, the first step leading directly toward medical social service was taken with a view to the education of the medical student; though in making this statement we are not forgetting the influence of the volunteer hospital visitor who for years has been interesting herself in the welfare of the patients, nor are we unmindful of the effect of the growth and development of other branches of public health nursing.

In 1902, Dr. Charles P. Emerson, recognising that much would be gained if the eyes of the young doctor could be intelligently opened to the social needs of the sick, organised a group of medical students of the Johns Hopkins University for a study of social subjects. This was done through affiliation with the Charity Organisation of Baltimore, the object being to give to the medical students a working knowledge of the social aspects of medicine, and also to give to them an understanding of the function of the social worker as a professional entity with whom they could advantageously co-operate. Training schools for nurses have also in a few instances made a practice of sending out their pupil nurses to do home nursing among discharged and dispensary patients. The Presbyterian Hospital in New York, though not the first training school to do this, inaugurated an excellent course in 1904. Something, however, more nearly resembling what we now know as hospital social service was introduced into English hospitals as early as 1895, in the form of the "lady almoner," whose function it was to decide as to the applicant's eligibility for free treatment and his needs as to material relief. Where other than hospital care was required, the lady almoner through co-operation with other agencies procured it for him.

Medical social service as we now understand it in this country, owes its existence to Dr. Richard C. Cabot, who first introduced it in the Massachusetts General Hospital, and who has done so much to further the growth of the movement all over the country. Miss Garnet C. Pelton has the honour to be the first medical social worker in the United States, but owing to ill health the work soon passed into the hands of Miss Ida M. Cannon, who has carried it forward with such marked and signal success. Both Miss Pelton and Miss Cannon are nurses.

The need of such work must appeal to every nurse who will add to her mental picture of the life of her ward patients, and of those coming to the out-patient department, an imaginative picture of the home problems which sickness has probably induced. Normal life is adjusted to healthful people, and the moment that a man becomes ill, in however slight a degree, he is out of adjustment with all the circumstances of his life. The difficulty is, of course, greatly increased by prolonged illness or chronic invalidism. It is unnecessary to enlarge on the individual problems presented by sickness: the family without the necessaries of life because of the illness of the wage earner; the child for whom it is impossible to obtain either proper treatment or necessary surgical appliances; the homeless man going out of the sheltering doors of the hospital without money or friends; the young girl facing an unmarried motherhood; the cardiac case which can only keep well under specially favourable conditions; the mentally ill; the would-be suicide for whom life seems insupportable; the crippled or otherwise handicapped; and all the long list of those confronted by difficulties, perhaps insignificant in themselves, but at the same time preventing recovery. For all of these, more than a physical diagnosis and more than physical treatment, is necessary. It is manifestly impossible that this should be given by the doctors, whose hands are already full with

the physical aspect of their cases. Hence the necessity of the medical social worker who will as far as possible supplement the work of the physician by the removal of obstacles to the success of his efforts, and who will also perform a valuable service by the accumulation of such social data as will assist in the scientific study of the conditions which produce and foster ill health.

Medical social service has been started in several different ways: by the hospital itself, either directly or through its training school; by outside agencies whose only function is hospital social service; and by other institutions, such as visiting nurse associations, or charitable organisations, which place workers in hospital dispensaries as one phase of their own activity. Though much good work has been done under all these systems, it seems to be the consensus of opinion that, ideally, medical social service should be an integral part of the activity of the hospital itself. It is felt that only in this way the true spirit of social service will permeate all departments, and become a part of the working spirit of the institution.

As the problems of the patients visiting the out-patient departments differ somewhat from those of the ward patients, it is not unusual to find a rather sharp line of demarcation between the working forces of the two social service departments. Not infrequently a worker is placed in the dispensary before such work is begun in the hospital itself, or vice versa, and when the second branch of the work is started there is not sufficient connection between the two. This is unfortunate, because the difference in the problems presented by the two types of patients is more apparent than real, and, since ward patients often become out-patients, while out-patients in their turn often enter the hospital, such a separation tends toward duplication of effort and lack of continuity of plan. Where a social service department is large and the workers more or less specialised, the same worker should have

charge of all the patients presenting the same type of problem, whether they become residents of the hospital or merely come to the dispensary.

The question of what a medical social worker shall do, is only equalled in difficulty by the question of what she shall not do. Everything in life is a part of something else, and the outlines of all branches of social work so merge in each other that the boundary lines must be capable of elasticity in every direction. At the same time the topography of all such boundary lines ought to be clearly understood by those who expect to travel satisfactorily.

It goes without saying that the welfare of the whole community is the ultimate desire of all the social agencies at work, and by welfare is not meant any single aspect of the life of the individual, but all its aspects. Work, without health to carry it on, is of no more use to a man than health without the means to gain a livelihood. Work and health without religion or recreation produce spiritual starvation, and the loneliness of the friendless means an unhappiness akin to death. All these things without education leave the individual hopelessly handicapped if he expects to rise in the world, and so on through all the phases of human existence. A nurse is apt to have her thoughts so focussed on the results of illness that she is inclined to feel that if health can be secured all else is of minor importance. In doing medical social work, therefore, she must rigorously train herself to see the patient's life as a whole, and in seeking causes and striving for results, realise the interdependence of his various needs each on the other. Nor can she stop here.

Outside of a hospital bed no one lives unto himself alone. Each man, woman and child is probably a member of a family, and certainly a member of a community, and as such he must be considered. As a rule, the interests of the patient, of the family, and of the community are alike

best furthered by the quickest possible recovery of the patient, but occasionally these interests are at variance, as when a woman's convalescence must be prolonged because the temporary breaking up of the home, resulting from her removal to a hospital or convalescent home, might mean the return of her husband to the alcoholic habit from which devotion to his wife is slowly weaning him. Or again, as when a child suspected of carrying some form of contagion must be kept from a much-needed outing for the protection of others. Also the effect of example must sometimes be considered. It is less difficult to deal with the widow struggling to bring up her young family than to deal wisely with the deserted wife, who presents outwardly exactly the same problem but who, if helped in the same way, may prove a stumbling block to other wavering husbands, because they may well feel that it is alluringly easy to temporarily unburden themselves of the responsibility of their families. All these things make a large view of her work necessary for the social worker.

What shall constitute the unit in the various aspects of social work is as yet an unanswered question in most communities. Shall tuberculosis be considered as a whole by those interested in its eradication? Shall all baby work be undertaken by a single agency? If so, shall the tuberculosis nurses working under a tuberculosis league be present at the tuberculosis clinics of a hospital which has a social service department? Similarly shall children's nurses make routine visits to babies discharged from the infants' wards, so many of whom they have themselves been instrumental in sending there, or shall this duty be left to the medical social worker? The problem also appears in another form. The Sullivan family have been known for years to the Charity Organisation which may or may not have been successful in accomplishing the ends desired for them. When illness brings

the undernourished Sullivan children to the hospital, shall the medical social worker deal with them, or shall she again refer them to the Charity Organisation? If the Sullivans are so referred, where shall the line be drawn in regard to other patients, as so large a majority of those needing assistance are already known to one or more of the various philanthropic agencies of the city? Again, at what point shall the social worker cease her own ministrations for her cases? With the constant influx of new patients it is manifestly impossible to carry them through the long process of family rehabilitation, so often necessary for their establishment on a secure footing. All this sounds most difficult of adjustment, but in the actual working out it is not as difficult as it sounds.

In the establishment of any new agency for the betterment of conditions it is a safe underlying principle that nothing shall be undertaken that is already being done, or which can be done to better advantage, by some one else. If this principle is kept firmly in mind, many problematical situations will readily adjust themselves. Where there is a visiting nurse association, the medical social worker, though a nurse, should attempt no home nursing for the very simple reason that an agency already exists to do that particular thing and presumably is equipped to do it as well and as economically as is possible.¹ The presence at special clinics of nurses who will carry the responsibility of tuberculosis cases, children, or neurasthenics, even though these nurses belong to the staffs of outside organisations, will rarely prove a source of regret to the over-busy hospital social worker who usually sees before her more avenues of usefulness than she can possibly find time to enter. A good working plan

¹ Home nursing is done by some hospitals as a part of their nursing service, both for discharged ward patients and for dispensary patients, but this is not medical social service in the sense in which that term is now being used.

of co-operation and mutual advisory assistance can easily be devised, and the hospital social worker thus freed for other developments of her work.

In meeting the question of overlapping with the work of other charitable organisations, a first step should always be the discovery of the other agencies which have already dealt with the family. In cities where there is a confidential exchange this is a simple matter, and consultation with the exchange should be a part of the routine management of every case. Indeed, to those accustomed to its use, social work would seem very complicated without it. The confidential exchange is a bureau for the exchange of a single piece of information, namely, the names of the agencies who have dealt, or are dealing, with an individual or family. A card catalogue is kept by which, on inquiry by responsible persons, it can be readily ascertained whether a family is known to other agencies or interested people. If so, this information alone is given, and the inquirer may then communicate directly with the other agencies involved, it being in their power to give or withhold such information as they think best. Where no such exchange exists, reliance must be placed on information furnished by the patient himself, sometimes a not very satisfactory method, as patients are less ready to be frank about their economic difficulties than about their physical ones.

As regards the closing of cases. No case should be closed until the desired end has been attained by the medical social worker herself, or until the patient has been placed in the hands of another responsible agency which may be expected to deal with him conscientiously and wisely. The convalescent home, that easy way out of so many difficulties, must not be looked upon as terminating responsibility. In many cases, a few days or weeks of rest and building up are all that is needed to put a patient on his feet; in many others recourse to the con-

valescent home merely postpones the day when a problematical situation must be met.

The question of the desirability of a relief fund for the use of the medical social worker is an open one. It is generally agreed that anything like permanent relief should not be given from the hospital. The reasons are much the same as those which make it seem unwise that other public health nurses should administer such a fund. As regards an emergency or loan fund, however, there is a difference of opinion. A few workers feel that even in emergency distinctly relief giving agencies should be called upon for the necessary assistance. Others feel that a small fund which can be called on for emergency need, and for very simple necessities such as the provision of car tickets, or the purchase of warm clothing for a patient leaving the hospital, is a great saver of time. Still others feel that the furnishing of surgical apparatus of all kinds, braces, artificial limbs, etc., or of glasses for eye patients, is logically as much the responsibility of the hospital as the furnishing of medicine, and that these things should be sold at prices within the means of the patients, or even provided free of expense by the social service department when absolutely necessary. Loan funds have in some hospitals been administered with success. If such a fund exists loans should be made on strictly business principles, and payment exacted to the last penny.¹ Otherwise they will prove demoralising to those to whom money is lent or credit extended. The whole question of relief giving is a most difficult one, and if it is to be undertaken by the medical social worker she should make herself thoroughly conversant with the methods which have proved themselves most effective and least fraught with danger to the recipient. All giving should be part of a

¹ The writer is told that this principle, so excellent in theory presents great practical difficulty, and that loans can by no means always be collected.

well-considered plan, and not merely the unskilful treatment of an obvious symptom.

There is one situation which sooner or later is sure to arise, whether relief is administered from the hospital or not. This is where there is a difference of opinion between workers as to the necessity or desirability of aiding a specific case. Every charity organisation has on its lists families who have from one cause or another so persistently resisted every effort toward rehabilitation that a policy of withholding help either to bring them to certain terms or to cause an actual break-up is reluctantly decided upon. If such a family falls into the hands of the hospital social worker and receives financial assistance from her, all the difficult disciplinary measures of the charity organisation will have gone for naught. The medical social worker must be very certain of her own superior judgment or insight before lightly giving her aid. The best method of dealing with cases involving a difference of opinion as to method is to call a meeting of all those interested in the family, when a systematic plan can be formed and each agency or individual assigned a part which will make for concerted and effective action.

This brings us to the question of whose authority shall ultimately decide important issues, involving perhaps a complete rearrangement of the whole life of a patient. Many authorities feel that such decisions should never rest on the judgment of any single individual, no matter how perfect her social training may be. For this reason case committees, or weekly conferences, have been inaugurated at which all cases presenting problems difficult of solution can be brought up, the social worker abiding by the decisions of the committee. The personnel of such committees is of two types. They are sometimes composed of experts and professional workers, and they are sometimes made up entirely of volunteers. The former type of committee has the advantage of providing

highly specialised advice for the various aspects of the different problems; the latter, the advantage of interesting and educating a number of people of the class upon whom the support of philanthropic work must always rest, and who, if the committee is well-selected, bring to bear upon the questions discussed vastly different points of view. To be of any value, attendance at these conferences must be regular, and a sense of individual responsibility felt by all the members. Much will depend on the ability of the social worker to bring to her committee a vivid picture of actual situations, clear and distinct, and without any touch of the picturesque exaggeration which is sometimes such a temptation if the worker has an appreciative love of the dramatic. Exactly the same care should be taken to state facts as facts, and surmises as surmises, that the nurse has been taught to exercise in describing physical symptoms to the physician. Often most important issues depend upon information which the social worker alone possesses, and absolute accuracy of statement is a first necessity. It goes without saying that in reporting to such a committee the point of view of the patient himself must be given due prominence. Any plan which can be built on the foundation of his own wish has a double chance of success.

In addition to these case committees or conferences there should be, for every hospital social service department, a special committee to take the responsibility of general policy and development. Even in a small hospital the social worker requires the support and guidance of a group of people whose interest is focussed on hospital social service. Such a committee should be thoroughly representative of the hospital itself.¹

¹ The Social Service Bureau of Bellevue and Allied Hospitals, New York, is administered by an Executive Committee composed of the following representatives of the hospitals: the President of the Board of Trustees, the General Medical Superintendent, the General Superintendent of the Training School, representatives of the Medi-

As the work of a hospital social service department grows and workers are added, the old familiar question arises as to whether there shall be specialisation for the various types of workers. It has usually been found in large hospitals such as Bellevue in New York, the Massachusetts General in Boston, and a number of others, that the assignment of the different types of cases to special workers has produced excellent results. The usual divisions are tuberculosis, sex problems, psychopathic cases, children and the general cases which do not fall under the preceding classifications.¹ Occasionally, there is still further specialisation and the establishment of special workers to take charge of orthopedic children, prenatal work, cardiac cases, infants, eye cases, or the finding of employment for the handicapped.

One opportunity of a hospital social service department is not always grasped, namely, the educational opportunity for the pupils of the training school. Though it is impossible to give to undergraduate nurses anything approaching thorough training in medical social service work, it is possible to give to them an insight into some of the social causes of sickness. If pupil nurses spend time in the social service department of their hospital the responsibility of their instruction must be recognised and the educational possibilities of the department developed for their benefit.

cal Board and the Out-Patient Department, the Commissioner of State Charities Aid Association, and the chairmen of committees of the various hospital divisions. Report of Social Service Department. Bellevue and Allied Hospitals.

The Committee administering the Hospital Social Service work at the Massachusetts General Hospital numbers among its members: the Superintendent of the Hospital, one of the Board of Lady Visitors, two medical men, one surgeon, one pediatricist, one orthopedist, one neurologist, two trained social workers and two business men. Ida M. Cannon, "Social Work in Hospitals."

¹ "Some Possibilities in Hospital Social Service Work." *Public Health Nurse Quarterly*, 1914.

Because technical nursing skill is not required in hospital social service, there is, perhaps, no branch of public health work in which volunteer workers can be used to so much advantage, but it must be recognised that the efficient helpful volunteer is not likely to be found ready-made, but must be developed by training, as are all other efficient workers. In considering the question of making use of volunteer assistants, it ought to be clearly understood that their supervision and assignment of work will take a very considerable toll of the time of the professional worker. However, a good band of carefully selected and well-trained volunteers is so great a source of strength to any hospital social service department that time cannot be better spent than in the development of such a group. Nurses, who are used to the military discipline of hospital training, and are only accustomed to supervise the work of other nurses, do not always understand volunteer workers. They over-estimate or under-estimate their capabilities and what may be expected from them, and they make the mistake of demanding either too much or too little in a variety of ways.

It must always be remembered by the professional worker that she has so arranged her own life as to make her work her first duty. The life of the volunteer on the other hand is necessarily so arranged as to make other duties of paramount importance. Therefore, though every effort should be made to secure regularity and promptness from the volunteer, this must be borne in mind. The writer having tried to do both kinds of work to the best of her humble ability, has no hesitation in saying that the path of the professional, who can say with St. Paul "This one thing I do," is a smooth and simple one in comparison to that of the conscientious volunteer who is daily confronted with a multiplicity of conflicting demands.

A little practice will enable the head worker to marshal

her forces to advantage. One volunteer may lack initiative, but will be able to promise regularity of service; another may have the quick sympathy and understanding which will open the hearts of the unhappy, but she must do her work in her own good time; a third loves the compiling of statistics, but is shy and constrained with the patients; a fourth goes into a household like a ray of sunshine, but is inclined to be wholly irregular in her ministrations; a fifth is so full of initiative that she keeps those who supervise her work vibrating between admiration of her powers and agony of mind as to the results of her cyclonic methods. Occasionally the ideal is found in the wise tactful man or woman who is able to give such regularity of service that its value equals or exceeds that of the professional worker.

A few general rules may be set down for the guidance of the nurse dealing for the first time with a group of volunteers. Do not expect from them exactly the same service as that expected from the professional. Do not undervalue their special and varying capabilities. Sort them carefully so that each may do the work for which he or she is best fitted and is happiest in doing. Expect and obtain regularity of service where it is possible, but be patient with the claim of other duties. Encourage initiative, but do not allow free-lance work. Require written reports of all volunteers, and insist on accuracy of statement. Do not let the patients suffer from the inexperience of the volunteers, or from their desire to do work for which they are not fitted. Remember that while leadership must be maintained, different methods are necessary from those used with subordinate nurses whose training has taught them to understand the meaning and necessity of authority. Put yourself constantly in the place of the new volunteer who is, perhaps, for the first time encountering poverty and distress, and in your desire to do away with a sentimentalism which hampers good work, be very sure that the seed of real sympathy is fostered and developed to the

uttermost. It will rarely be found desirable to deal with any number of volunteers without frequent meetings held for instruction and discussion.

It is not enough that the medical social worker should do her own work well, and guide wisely the work of others. She must recognise the fact that accurate and suitable records are a very important part of medical social service. As the medical social worker is neither wholly a nurse nor wholly a social worker, so something, different from strictly medical or strictly social records, is required for a hospital social service department. Many pages might be written on the necessity and desirability of record-keeping, but as that necessity seems to be everywhere a conceded point, the practical issues connected with the question are all that need claim our attention, namely, what form the records shall take, and how the busy workers shall keep them.

It will be generally agreed that unless there are enough workers for the department, rarely, alas, the case, the minimum rather than the maximum of demand should be made for clerical work. The important question is, therefore, a determination of what constitutes the minimum amount of recorded information with which a social service department can be well and adequately conducted.

There are, as Miss Cannon points out in her most valuable book "Social Work in Hospitals," two types of records required, the statistical and the narrative, serving the following purposes:

First. To aid the memory of the worker.

Second. To portray the conduct of the case so satisfactorily that a succeeding social worker shall have a complete history of all that has already been done.

Third. To aid the study of methods of investigation or treatment and to contribute to their betterment.

Fourth. To provide material for case-teaching as a means of instructing students in hospital social service.

Fifth. To promote medical social research.

Sixth. To deepen and clarify the workers' reflections upon the problems that social service encounters.¹

The form of record recommended by the committee on records of the New York Conference on Hospital Social Service (1915) includes the following elements: index card, slight service card, face sheet, narrative history, and monthly or yearly report.²

The purpose of the index card is identification. The slight service card serves the double purpose of index card and record of slight service for cases on which little work is required. The face sheet gives such facts about the case as are needed for constant reference. The one presented by the committee shows four divisions: the first for identification, the second for information regarding the individual, the third for information regarding the household, and the fourth for information as to previous medical diagnosis, etc. Space is also arranged for the names of interested individuals or agencies. The narrative sheet contains an account of individual details and of all action taken upon the case. The committee recommends that the monthly report include the following points: first, the number of admissions to hospital or dispensary; second, the number of patients interviewed; third, the number of patients found in need; fourth, the number of cases given slight service; fifth, the number of cases investigated; sixth, the number of cases taken under care; seventh, the number of former cases that are carried over from the previous month and the number of old cases that are reopened. In addition, it is recommended that the yearly report indicate a list of social needs as they are shown by the inability to secure adequate assistance for the sick.³

¹ Ida M. Cannon, "Social Work in Hospitals."

² Dr. Sidney E. Goldstein, "A Record System for Medical Social Service." (Committee Report.) Proceedings of New York Conference on Hospital Social Service, Vol. II.

³ "A Record System for Medical Social Service." (Committee

In some hospitals the family is made the unit of investigation, and the initial card is made out for the family, individual cards being added as its various members become patients.

It goes without saying that inaccurate records are worse than no records at all, and the social worker should strive not only for accuracy but for brevity. A too long narrative record is almost as useless as one that is incomplete, for vital points are lost in the mass of unnecessary information. The medical record kept by the physicians is usually filed separately from the social record, but all cases handled by the social service department should be so marked, with additional cross references to simplify use. Occasionally, certain social data are entered on the medical record as a matter of routine, or entries in coloured ink are made regarding special pieces of information contributed by the social worker concerning occupation, family history, or some point affecting diagnosis. Slightly different record forms may be desirable for different departments of the work, as emphasis is placed on the importance of various aspects of the social situation, or specially prepared blanks may be used for investigation into conditions affecting certain diseases which will give the required information in desired form and in uniform sequence.

All records, dealing as they do with the intimate and private affairs of the patients, should be kept in carefully locked cabinets when not in actual use. The worker must not forget that though the patients are, perhaps, but names to her, except as she touches them in her work, any one of them may be the next door neighbour of the woman who cleans the rooms or of the man who washes the windows, and human curiosity is a trait to be reckoned with. Access to the records should be very charily given, though in-

Report.) Proceedings of N. Y. Conference on Hospital Social Service. Vol. II.

formation from them may be freely furnished to those who wish to study any of the phases of social conditions.

The question of how the medical social worker shall find time for record-keeping is one of insuperable difficulty if the keeping of records is looked upon as a desirable, but not wholly necessary, part of her work. Leaving aside the value of records for other forms of public health nursing, for hospital social service, they are so necessary that it is unquestionably better to limit the scope of the undertaking, rather than to economise unduly in time spent upon them. It is rarely desirable for the social workers themselves to do the actual writing. It is better to have such work done by those trained to shorthand and clerical work, whose salaries will in the end be found a true economy. In Miss Katharine Tucker's opinion there should be one clerical worker for every three social workers.¹ Hours for dictation should be systematically arranged and time saved by thoughtfully prepared notes.

In the selection and limitation of the cases cared for by the hospital social worker, different methods obtain in different hospitals. The social worker may herself see and talk with all patients admitted to the hospital, both at the time of admission and before discharge. In the case of children, she may make a routine visit to every home, in order that the child may not return to conditions inimical to convalescence. She may, on the other hand, be obliged to limit her work in the wards to those patients who are brought to her notice by the doctors and nurses, although this method is less satisfactory, for being untrained to such work, and it being with them a secondary consideration, doctors and nurses do not always select the cases most needing social service. The admitting desk is always a strategic point for the social worker, but where the staff is small, or consists of a single worker, and patients are ad-

¹ Proceedings of N. Y. Conference on Hospital Social Service, Vol. II.

mitted at all hours, it is obviously impossible to be always there.

In the out-patient department, or dispensary, it is sometimes the duty of the medical social service worker, like the lady almoner of England, to decide on the eligibility of the patients for free advice or treatment. Where this is so, such work should not be regarded as routine drudgery carried on for the purpose of saving the hospital from imposition, but as a valuable opportunity for ascertaining the real needs of the patients. Ideally, it is desirable to have a social worker in every clinic, as in this way the social and physical aspects of the cases are dealt with side by side in the simplest and most natural way, the doctor learning to rely on the worker's social diagnosis and assistance, and the social worker gaining a thorough insight into the medical situation. Where this is done, there is sometimes a temptation to economise in the time of nurses, and to allow the social worker, if she also be a nurse, to assist the doctors by taking temperatures, undressing children, etc. This is a poor arrangement, for the worker's time should not be diverted from her legitimate task of talking with the patients and furnishing the doctor with such illuminating information as she may have gleaned from her home visiting.

As regards the limitation of cases, if limitation is necessary. It is usually best to undertake only what can be done well, even though certain branches of the work must be left untouched, but in any method of limitation, a definite plan should be followed. Sails must, of course, be set according to the wind, and in its early days the value of hospital social service can often best be demonstrated in certain departments or clinics where the doctors are particularly sympathetic to the new movement, but as the work becomes established a thoughtful survey of the needs of the whole hospital should be taken, and the workers placed where most can be accomplished by them. Wise co-opera-

tion is a more important factor in the saving of time than is always realised, and it will sometimes be found that a conscientious worker is unable to get through her own work for the simple reason that she is trying to do the work of other people.

The objects of medical social service might be summarised somewhat as follows: to bring to the doctors such information as will help them in their diagnoses and to so rearrange the patient's social situation as to make possible their recovery and the carrying out of the doctor's orders; to protect the community from communicable diseases; to simplify the work of other social agencies and to interpret the hospital to them; to bring to the patient that touch of personal interest in his affairs which will lessen his fear of the big institution. Perhaps, most important of all, to collect and tabulate data which will aid in the study of the social causes of disease. Let no nurse feel that in undertaking such work her years of hospital training will have been spent in vain. Every particle of her nurse's knowledge will add to her ability to make medical social service the link which it ought to be between medical and social work, and between the hospital and the community which it serves. The medical social worker has not only the joy of personal service, but she is often directly engaged in the seeking of causes, always a broadening and interesting form of work. When the great question can be answered as to the causes of the diseases that bring people to the hospital, a long step will have been taken toward their prevention.

CHAPTER VII

RECORDS AND STATISTICS

THE subject of record-keeping has probably never been discussed at a convention without some agitated nurse arising to ask if she is expected to neglect her patients in order to write down information about them. It is a question easily answered from the convention platform, and is usually dismissed with the reply that such is not the case, but ways and means of meeting the difficulties of efficient record-keeping are not always made clear. The attitude of many boards of managers is so lukewarm toward the importance of both records and statistics that the nurse finds little to encourage her in keeping them, and the work is not infrequently so arranged as to allow no regular time for them, in which case record-keeping is either done at the expense of the patient's welfare, or at the expense of the nurse's own much needed free time.

The keeping of records is not merely a desirable addition to the useful work of the nurse, but in the long run is as important as any of her ministrations in the homes of her patients.

Records are kept for two purposes; first as a form of indispensable bookkeeping which will enable those managing the work to know whether or not it is being run on good business principles, and secondly, as a means of gathering data which will give accurate information concerning the various aspects of illness and health.

Let us first consider the question of bookkeeping. Dr. Goldstein tells the story of a man who was started in busi-

ness by the present of a sum of money with which he bought oranges at a dollar a hundred. He sold them at a cent apiece and was amazed when all were gone to find that he had made no profit. An extreme example of lack of bookkeeping, perhaps, but it is not without its parallel in the experience of more enlightened individuals than this unfortunate vender of oranges.

The funds of almost all visiting nurse associations are carefully administered, the accounts properly audited, trust funds wisely invested, and books kept in an orderly and business-like way. How many associations, however, know the exact cost of each visit paid,¹ or the price of administration of the different departments of the work in which they are engaged? Yet no business could be successfully conducted without an exact knowledge of the cost price of the commodity sold. It may be urged that a public health nursing organisation is not a business enterprise, and that as a rule there is little connection between the receipts and the expenditures, the former coming in the shape of income and gifts, rarely to any large extent in payment for services rendered. Surely, though, no type of business enterprise more urgently requires a good system of bookkeeping, if it is to be intelligently administered, than one which sells its commodity on a sliding scale, and also gives it away without recompense. The trouble usually lies in the fact that no one is interested in using the treasurer's figures in their relation to the work done.

A few simple facts should be known by every association. A treasurer's report gives information as to the sources of income. It also shows the amount of money expended for overhead expenses, for rent, telephone, office equipment, etc., for salaries, for transportation, for sup-

¹ In voluntary organisations it is impossible to reckon the exact cost of nursing because a certain amount of unpaid service is rendered by members of the Board of Directors and others, the money value of which it is impossible to compute.

plies, for sending delegates to conventions, and for any special or unusual activities carried on. The superintendent's report gives the number of patients, the number of visits, and a more or less full statistical report of the type and disposition of the cases. In how many organisations, however, are these reports studied for the purpose of drawing an analogy between the two? Even the fundamental principle that time represents money is not always clearly understood, yet this fact is peculiarly true of an enterprise which daily accomplishes the amount of work required of it by adding the necessary number of employés.

Nurses' meetings are highly desirable and necessary, but the cost of a nurses' meeting should be clearly recognised. If sixteen nurses attend a meeting lasting an hour, and requiring another hour for travel to and fro, it is quite evident that thirty-two hours of the time of the staff has been spent, and this represents the working day of four nurses. If these meetings are held regularly, the annual cost can easily be computed. If nurses are present at clinics or baby consultations, the cost of such attendance should be exactly known. It is well also to know the amount of time spent by nurses between cases. Sometimes a somewhat more expensive mode of transportation will prove an economy. One particular service may be run at a greater expense than another, and if this fact is not made evident, a false impression of the cost of a visit will be given. An advisory service is usually carried on at a greater expense per patient than a working service, the reason being not so much because of the amount of time actually spent with the patient, but because such special nurses generally spend more time at clinics or in making arrangements for their patients' welfare, and the time spent upon each patient is not well represented by the mere enumeration of the number of visits made at his home. If a visiting dietitian or domestic educator forms part of

the staff, this form of work will usually prove so expensive as reckoned on the visit basis that a wholly erroneous conception of the cost of nursing visits will be gained unless the various services are tabulated separately. These few causes of vagueness of apprehension regarding the business situation may be supplemented by any one whose experience has taught them the difficulties of such book-keeping.

Some associations feel quite hopeless about attempting any comparative form of bookkeeping, because of the complexity of the salary question. A sliding scale is quite universal and changes in the staff whereby newer nurses are advanced to higher salaries and older nurses are replaced by new nurses at lower salaries imply a constant readjustment of the pay roll. Where pupils are sent out from hospitals to work with an association no salaries are paid, but their work cannot be accounted as without expense because of their transportation, the supplies used by them, and the cost of the time spent in their supervision. The various services are sometimes a source of difficulty in that the use of supplies by advisory nurses differs from that of nurses giving bedside care. All these complications present no insuperable difficulty to the trained accountant or statistician. Money will be well-spent in paying for the services of an expert accountant who in a few hours will be able to devise a method of bookkeeping which will usually surprise by its simplicity those unversed in such matters. Sometimes, such an expert may be found who is willing to give this valuable assistance as his contribution to the care of the sick of his city.

All organisations strive for economy but many try to attain it in the wrong way, mainly because their system of bookkeeping does not give them the facts.

An effort may be made to keep down expenses, accordingly insufficient office room is rented, one telephone line is installed instead of two, dime messenger service is re-

duced, salaries are not raised to meet the increased cost of living, and general discomfort prevails. What is the result? The nurses are not suitably accommodated in the office, so time is lost. They must wait to use the telephone, so time is lost. They are called upon to go a little out of their way to do an errand that might be done by a ten-cent boy, so time is lost. They live uncomfortably because board has become higher and consequently do not feel as energetic as formerly, so time is lost. The same thing pertains with the office force. Money is saved in the wages of a cleaning woman, so the assistant superintendent, drawing a salary of from twelve to fifteen hundred dollars a year cleans the shelves in what she calls her spare moments, while the stenographer spends her sixty or seventy dollars a month time in assisting her. There is no extension telephone on the stenographer's desk, so, perhaps, fifty times a day she leaves her work and steps into the next room to answer a call. The salary of an additional office assistant is saved, so filing, copying, etc., is done by women paid at an exorbitant rate for such work.

Let the superintendent of an organisation so managed take pen and paper in hand and add the additional annual expense of suitable office quarters, of an adequate telephone service, of a free use of messenger boys, of the wages of women to clean, and of clerks to do inexpert office work. Let her then add the expense of the unnecessary loss of time of each nurse and office employé and she will find herself in possession of some illuminating figures to present to her board. Seventy, eighty or a hundred dollars is not too high a salary to pay to a well-trained woman for expert nursing service, but it is an absurd price to pay for the cleaning of shelves, or the running of errands, and a still more sinful waste when it is paid for time spent in unnecessary waiting to use a telephone or other office con-

venience. Any one can be penny wise, but it requires intelligence and a good system of bookkeeping to prevent pound foolishness.

The loss of time from diminished energy brought about because the nurses' salaries do not permit of comfortable living conditions, is not so easily computed, but some estimate may be made by a comparison of statistics covering a long period of time. Sometime it may be possible to make such comparative studies with the aid of the annual reports of other public health nursing organisations. A much needed reform in the methods of issuing annual financial statements will, however, first be necessary.

When a public health nursing organisation has succeeded in working out a good individual system of bookkeeping it has only attained an individual success. A clear insight into the business principles of public health nursing administration will never be possible until some comparative study of the financial reports of other organisations can be made. At present any effort to study different annual reports with a view to gaining helpful information as to relative expenditure is a sadly disappointing task, and the wastefulness of losing such educative opportunity is lamentable.

It is to be hoped that before long some effort will be made toward uniformity of financial report, and when this time comes every public health nursing organisation should be ready to so re-arrange its financial and statistical statements as to conform to a general plan. The various sources of income should be defined; overhead and staff expenses, separately tabulated; the cost of visits and the amount and sources of payment for the same so set forth as to make plain to what extent the organisation is self-supporting; the number of nurses, not alone their names given; special expenses (if milk, ice, or other relief is given) placed in a separate account; all house accounts, if

a nurse's home is maintained, kept in such a way as to make plain the proper relation between board and salary of nurses.¹

In many annual reports these items may be found, but only after hours of labour can anything like comparative deductions be drawn and only in rare instances do such deductions prove really helpful. Correspondence usually elicits the fact that "overhead expenditure" means one thing in one city and something quite different in another, or all deductions are rendered valueless because of the omission of some important piece of information, no mention, perhaps, having been made of the fact that offices are secured rent free, thus unexplainedly reducing office expenses.

It would seem unnecessary to further insist on the value of bookkeeping. The keeping of such statistics as will make possible an intelligent study of the relative cost of all parts of the work, ought to be so obvious a necessity as to need no urging, for it is a matter merely of efficient house-keeping. When it comes to the type of statistics which deal solely with disease, its causes social and otherwise, its relation to age, sex, nationality, housing conditions, locality, etc., the disposition of the case and the results of nursing care, there is great difference of opinion as to the amount and kind of information required, and the method of recording it.

In no department of public health nursing has so great a change in the general point of view been manifested. Fifteen, even ten years ago, visiting nurse associations prided themselves on their economy in the matter of record-keeping, and it was only a few of the more enlightened which kept anything but the simplest form of record, as a rule a mere identification card for each patient being thought amply sufficient. A change of

¹ Anna M. L. Huber, "Relation of Overhead to Staff Expenses." *Public Health Nurse Quarterly*, July, 1916.

attitude toward the whole question of statistics was brought about as a natural sequence to a change in the conception of the duties of a public health nurse. The early nurses gave bedside care and taught the principles of hygiene in the homes, but were not expected to concern themselves with the causes of the conditions which they found. It was impossible, however, that an intelligent band of women should long continue to work in this way. Some among them could never be content with alleviative measures alone, and the first utterance of the question, "Why must these conditions exist?" opened the door for another type of work and one requiring a different form of record. The early public health nurses also worked with little co-operation. Many of them administered small relief funds, and themselves did a number of the things which later it was found desirable to do through other agencies. The moment a nurse called in other assistance for her patients she needed a certain amount of written information about them, which was not necessary when she herself ministered to their various needs and carried all of their affairs "in her head." In addition to these changes the mere numerical increase of patients under care made more complete records necessary.

Just what form those records should take, however, is a question still causing much discussion. It would, of course, be very desirable if a uniform type of record could be kept by public health nurses all over the country, but there are a number of obstacles to this Utopian plan. In the first place, it is evident that the same amount of written information is not needed in a small village where the nurse is, perhaps, the only social agent at work, that is required in a large city with its complexity of social machinery. Also, when the question of uniformity of record was considered by a special committee of the National Organisation for Public Health Nursing, it became evident that the records required for the various branches of the

work differed in many points. Certain characteristics are common to all, but the record necessary for one branch of specialised nursing was not found suitable for another, nor did the blanks which exactly fitted the needs of a worker in one city prove satisfactory to a worker in another. Notwithstanding this natural divergence of requirement, the committee felt it would be desirable if at least a certain minimum of data could be obtained by every public health nurse.

After careful consideration the committee decided upon ten essential points. The ten points were as follows:

1. Sex.
2. Marital relation (single, married, widow).
3. Race (white or coloured).
4. Age.
5. Place of birth.
6. Nationality of father, of mother.
7. Occupation.
8. Diagnosis.
9. Number of visits.
10. Condition on discharge.

To nurses working on the staffs of big city organisations, this degree of information will appear quite inadequate, but it must be remembered that it is only intended as a skeleton of identifying facts on which the well-rounded structure of a suitable record system can be built to suit local conditions or special forms of work.

In addition to these points it is generally found desirable to record on the face of the card the name of the physician or physicians, any complications of the patient's disease, his church connection, whether he is nursed free of charge or if nursing service is paid for and if so by whom, the source of reference to the association, and whether he is discharged to hospital, dispensary or to other care. It goes without saying that the patient's name, address, case number, and the dates of first and last visits

will be stated. Still more complete record blanks give space to the length of illness, when work was stopped, earnings, insurance or sick benefits, rent, conditions of house, the names of employer or interested agencies and individuals, with information as to the names, ages and occupations of other members of the family. Family record cards are felt by some nurses to give a more complete and satisfactory picture of conditions than is possible when blanks are provided for the individual alone. Others feel that the individual best represents the basis and that cross references to the cards of other sick members of the family are sufficiently informative.

For the special branches of nursing, special information will be required. Tuberculosis records will naturally give information as to the patient's possible or probable source of infection, whether he is careful or a menace to the community, the number of other tuberculous people in his family, etc. Infant welfare cards will give space to weight, methods of feeding and other special points affecting infant life. Mental hygiene cards will be informative on the heredity of the patient and on conditions affecting his nervous health. School cards will be so arranged as to follow the child from grade to grade giving a picture of his physical progress. Industrial cards will require space for special information regarding industrial conditions. Hospital social service records differ from other public health nursing records in that they more nearly approach the usual record form of the charity organisations and make use of a narrative record sheet in addition to the usual statistical card.

Some visiting nurse associations have found it possible to be of great assistance to their city boards of health by the division of their districts according to wards, and by the keeping of such detailed morbidity statistics as will make possible comparative studies.

In arranging any system of records two points may well

be considered; what is desirable and what is easily attainable, and a balance drawn which will provide at least for what is necessary.

That records should be accurate and should give a certain amount of social information is quite generally conceded, but the question constantly arises as to the value, beyond a certain point, of visiting nurse statistics. They are certainly helpful in the consideration of health problems, but they do not necessarily tell a true or full story of the actual conditions of civic health, because patients come into the hands of a visiting nurse association according to the law of chance. One patient may be nursed by the association while his neighbour on the right, sick of the same disease, is taken to a hospital, and his neighbour on the left, afflicted in the same way, is cared for by members of his own family. Therefore visiting nurse records can only be advantageously used in connection with other morbidity statistics. The question, too, of correct diagnosis is a difficult one where so many and so varied a type of doctor is dealt with. This is shown by the diverse diagnoses sometimes entered on a single card and covering a single illness, when there has been more than one doctor in attendance. This situation is naturally trying to the statistician endeavouring to draw accurate deductions, but it is one which a visiting nurse association is powerless to alter, since diagnosis is plainly out of the province of the nurse.

A third difficulty lies in the fact that patients are discharged for reasons not always attributable to health conditions. Those who die or recover form but a part of the number which pass through the nurses' hands. Many are discharged to other institutions, many to the care of an instructed family, some move away, and others do not desire the services of a nurse for reasons of their own. The following up of such cases for the purpose of recording their ultimate recovery or death has been found so expen-

sive a matter in the light of the expenditure of time, as to prove almost prohibitive.

Most of these difficulties do not apply to the special branches of public health nursing, or if they do, it is in a much modified form. The majority of the special branches meet or endeavour to meet the complete need of the group of people that they serve. They deal largely with specialist physicians who greatly simplify the question of correct diagnosis, and the nature of the work, as a rule, makes feasible a fair accuracy of statement as to the final disposition of cases, and the ultimate health situation of the patient. In addition, the very essence of the principle which governs the need of specialisation lies in the fact that an intensive study of the subject is implied. If such a study is not to be made, there are few who would uphold the desirability of specialised public health nursing, and no such study is possible without full and accurate statistics from which intelligent analysis may be made.

Plain common sense should be applied to the whole question of records and statistics. The local use to be made of them should receive careful consideration. If a city board of health will be helped by any particular piece of recorded information let it by all means be furnished. At the same time there should be moderation in the expenditure of the nurse's time for such work. A social worker once came to the writer with a record blank which he requested that the district nurses should fill out as they went from house to house, a very simple and easy task from his point of view. In addition to the usual questions concerning social conditions, he required an exact estimate of the amount of tobacco weekly consumed by the male members of the household, the amount and price of the liquor or beer drunk, together with much other information concerning the detailed expenditure of the family budget, the necessities and the luxuries being separately tabulated and

the whole representing for each nurse at least half an hour of daily clerical work in addition to the time spent, to say nothing of the difficulty in obtaining the information. We are not questioning the desirability of special pieces of investigation, but the obliging superintendent of a visiting nurse association in whom the spirit of co-operation has been strongly inculcated must not allow herself to be led away through a desire to be helpful into paths not legitimately her own.

The question of economy of time in the matter of record-keeping is one which should receive very careful consideration. Two general principles may be accepted. Printed blanks save time and therefore money, and trained clerical workers produce a like result. If nurses have no clerical work which can be done by a clerk, or write no letters which can be dictated to a stenographer, an actual saving of money will be effected, though this truth is sometimes obscured by the fact that the payment of salaries for office assistance shows very plainly on the account books, while the time stolen from the nurses' daily nursing work is not so clearly set forth. An exception to this must, of course, be made where a nurse recorder is employed who gives her entire time to statistical work, and also in the few instances when work is in that early stage of development in which a superintendent is required, but when her duties do not fully occupy her time.

Even the single nurse working alone will do well to obtain voluntary assistance when possible. She will undoubtedly be inclined to feel that it is easier to do everything herself than to tell some one else how to do it. This is true in the beginning, but is just as poor a principle when applied to records as when applied to any of the other duties of a public health nurse. There is no more pernicious doctrine for any form of growing work, than the one implied in the saying, "if you want a thing done, do it yourself." The inevitable result is that nothing will

ever be done which is beyond the powers of a single individual.

There will always be a certain amount of record-keeping which can be done by the nurse alone. After this amount has been reduced to the minimum by the use of printed blanks and clerical assistance, regular time should be assigned for it and this time should be accounted as belonging not to the patients or to the nurse, but to the record system. Only in this way can accuracy and promptness be insisted upon. A nurse does not always realise the loss of time and consequently of money caused by inaccuracy, but there is no reason why such costly carelessness should be more leniently judged than are mistakes in other departments of her work. Many nurses who thus waste the association's time do so quite thoughtlessly. Their cheerful explanation that they have no head for figures, is not, when analysed, very satisfactory, for as a rule the mistakes are not due to mathematical incompetence, but to a carelessness which they do not dream of displaying in the exercise of their nursing duties. Possibly one reason why many staff nurses dislike and undervalue this part of their work is because no one has tried to interest them in it. It is dull work to record facts, if one hears nothing of the deductions to be drawn from them. Every superintendent can spend time to advantage in telling her staff of the interesting facts brought out by their figures. Comparative statistics can always be made interesting if well set forth and few nurses will fail to respond to a stimulus of this sort.

If all public health nurses could be made to realise the importance and value of their work of record-keeping, if they would bring to it the same spirit of service and the same interest in detail that they bring to the care of their patients, if they could go a step farther and for one moment see the hour spent at their desk in its relation to the whole broad field of public health nursing, perhaps there

would be less impatience with this prosaic part of their daily task.

The laboratory worker has changed the course of thought, and therefore of action, toward many diseases and their treatment, and through his labours has affected the lives of thousands of men and women whom he has never seen. He would, however, have accomplished little if he had been content to make his experiments without recording their success or failure. The active nurse, working with the stimulus and incentive of personal service, has a lesson to learn from these unseen workers upon whose painstaking and impersonal labours the whole structure of her own work is built.

She, too, all unconsciously, may be making important discoveries which sometime may be used to increase the welfare of the human race in ways she does not dream of. Her written records, quite as much as the bedside care of her patients, may be the means to this end, so let her dignify her task of record-keeping with a consciousness of its importance and of its value, and bring to it if possible the same enthusiasm and the same whole-hearted gift of service that she is so ready to lavish in other ways, and that constitutes the very essence of public health nursing.

APPENDIX

IN writing or speaking on public health nursing subjects a few important dates are constantly required. The following list chronologically arranged contains those which stand out as marking the development of the movement. Absolute accuracy has been difficult because of frequent difference of statement by those whose authority carries equal weight. Work tentatively started under informal conditions is in most instances the cause of confusion, the date of formal inauguration being given in some accounts of the enterprise, the date of the earlier experimental effort in others. Under such circumstances the generally accepted date has been selected.

| | |
|--|---|
| 1050 | Hospital of St. John the Almoner established at Jerusalem from which grew the Fraternities of the Knights Hospitalers of St. John of Jerusalem, of Malta and of Rhodes. |
| 1182-1226 | St. Francis of Assisi. |
| 1207-1231 | St. Elizabeth of Hungary. |
| 1347-1380 | St. Catherine of Siena. |
| 1611-1615 | Visiting Nursing done by the Order of the Visitation of Mary. |
| 1638 | Society of St. Vincent de Paul founded. |
| From latter part of 17th Century to middle of 19th Century | So-called dark period of nursing. |
| 1798 | New York Hospital inaugurated a system of regular instruction for nurses. |
| 1813 | Ladies' Benevolent Society of Charleston, S. C. founded. |

- 1820-1910 Florence Nightingale.
- 1836 Pastor Fliedner created Modern Order of Lutheran Deaconesses at Kaiserswerth.
- 1840 Establishment of Nursing Sisters of Devonshire Square, London.
- 1848 The Society of St. John's House founded in London.
- 1859 The first District Nursing Association established in Liverpool by William Rathbone.
- 1860 Nightingale Training School for Nurses established at St. Thomas's Hospital, London.
- 1864 Treaty of Geneva. Inauguration of the Red Cross.
- 1868 The East London Nursing Association established.
- 1872 Training School for Nurses established at New England Hospital for Women and Children.
- (Sept. 1)
- 1873 Training School for nurses established at Bellevue Hospital, New York.
- (May 1)
- 1873 Training School for Nurses established at New Haven Hospital.
- 1873 Training School for Nurses established at Massachusetts General Hospital.
- (Nov. 1)
- 1874 The National Nursing Association inaugurated in London by the Order of St. John of Jerusalem.
- 1874 School Medical Inspection first established in Brussels, Belgium.
- 1875 The Metropolitan and National Nursing Association founded in England.
- 1877 Woman's Branch of the New York City Mission first organisation in America to send trained nurses into the homes of the sick poor.
- 1879 New York Ethical Society placed trained nurses in dispensaries.
- 1881 American Red Cross established as a permanent Society.
- 1885 Waltham Training School established.
- 1886 Boston Instructive District Nursing Association established.

- 1886 The Visiting Nurse Society of Philadelphia established.
- 1887 The Queen Victoria's Jubilee Institute for Nurses founded in England.
- 1889 Chicago Visiting Nurse Association established.
- 1892 School nursing first undertaken in London.
- 1893 Henry Street Settlement founded.
- 1893 The Society of Superintendents of Training Schools founded (now the League for Nursing Education).
- 1894 School Medical Inspection inaugurated in Boston.
- 1895 The Lady Almoner introduced into English Hospitals.
- 1896 The Nurses' Associated Alumnae founded (now American Nurses' Association).
- 1897 First industrial nurse employed at John Wanamaker's Store, New York.
- 1897 Victorian Order established in Canada.
- 1898 First municipal nurse employed in America at Los Angeles.
- 1898 London School Nurses' Society established.
- 1899 Hospital Economics Course established at Teachers' College, Columbia University. Afterward Department of Nursing and Health.
- 1900 The American *Journal of Nursing* first published.
- 1901 } 58 associations doing public health nursing and about 130 nurses. (Statistics presented by Harriet Fulmer at International Congress of Nurses in Buffalo.)
- 1905 } 200 associations and about 440 nurses. (Statistics presented by Ysabella G. Waters at National Conference of Charities and Corrections.)
- 1916 } 1992 organisations. 5152 nurses. 1496 cities or towns employing nurses.
- (May) (Statistics gathered by Ysabella G. Waters.)
- 1902 "Midwives' act" passed in England.
- 1902 School nursing started in New York.

- 1903 Tuberculosis nursing first undertaken as a special branch of nursing.
- 1904 School nursing taken over by London County Council.
- 1905 Medical Social Service Department established at the Massachusetts General Hospital.
- 1905 American Red Cross re-organised and re-incorporated.
- 1905 National Association for the Study and Prevention of Tuberculosis founded.
- 1906 First post-graduate course in District Nursing offered by the Instructive District Nursing Association, Boston.
- 1908 First Mental Hygiene Committee organised in Connecticut.
- 1909 The *Visiting Nurse Quarterly* first published. (Now the *Public Health Nurse Quarterly*.)
- 1909 American Association for the Study and Prevention of Infant Mortality founded.
- 1909 National Committee for Mental Hygiene formed.
- 1909 The Metropolitan Life Insurance Company first offered home nursing to its industrial policy holders.
- 1909 Jubilee Congress of District Nurses held in Liverpool.
- 1910 The course in Public Health Nursing established at Teachers' College, Columbia University.
- 1912 The National Organisation for Public Health Nursing founded. 1913, First Annual Meeting at Atlantic City. 1914, Second Annual Meeting at St. Louis. 1915, Third Annual Meeting at San Francisco. 1916, Fourth Annual Meeting at New Orleans.
- 1912 Rural Nursing Service of the American Red Cross established. (Now Town and Country Nursing Service.)
- 1912 Federal Children's Bureau established.

- 1913 State law passed in Ohio empowering the appointment of Public Health Nurses by the Medical Superintendents of County or District Tuberculosis Hospitals.
- 1913 Phipps Institute offered post graduate course in Public Health Nursing.
- 1913 First Health Centre established by the New York Health Committee.
- 1916 Western Reserve University established a course in Public Health Nursing in the School of Applied Social Sciences.
- 1916 Ohio State University established course in Public Health Nursing as part of Department of Public Health and Sanitation.
- 1916 Course of Public Health Nursing established at Simmons College.

THE NATIONAL ORGANISATION FOR PUBLIC HEALTH NURSING

THE National Organisation for Public Health Nursing came into existence to fill a very obvious need.

All over the United States public health nurses were being employed by industrial concerns, by small clubs, by churches, by municipal and state bodies, and by other agencies whose primary function was not nursing work, as well as by visiting nurse associations, tuberculosis leagues and child welfare societies existing for the purpose of health propaganda.

Though most of these organisations and agencies were earnestly endeavouring to do good and conscientious work, the only definite standards set were those of the larger organisations, whose methods and ideals might or might not be known to those newly engaged in the work.

Borne on the tide of a general public interest the public health nurse was everywhere demonstrating her value, but the thoughtful saw in the very force of this tide of interest a danger, unless the highest professional and ethical standards could be set and maintained.

In order to secure such standardisation a joint committee was appointed in 1911 by the American Nurses' Association and the Society of Superintendents of Training Schools (now the League for Nursing Education.) The members of the Joint Committee were:

Lillian D. Wald, Chairman

Anna W. Kerr

Jane A. Delano

Ella Phillips Crandall

Mary Beard

Mary S. Gardner

This Committee sent out to the 1,092 agencies then known to be engaged in public health nursing, letters setting forth the dangers of unstandardised work, and asking that delegates

be sent to the annual meetings of the two national nurses' organisations (the American Nurses' Association and the Society of Superintendents) to be held that year in Chicago.

The response was encouragingly enthusiastic and in June, 1912, the National Organisation for Public Health Nursing came into existence, with Lillian D. Wald of the Henry Street Settlement as its first president. Briefly, the object of the Organisation was the stimulation and standardisation of public health nursing, and furtherance of co-operation between those interested in public health measures. Like the League for Nursing Education, the new Organisation became an integral part of the American Nurses' Association.

Membership is of several types, allowing for nurse, lay and corporate representation. Active nurse membership is only conferred on nurses possessing specified professional equipment, and corporate membership only on organisations employing nurses, a given per cent of whom are eligible for active membership. In this way, a high educational standard for public health nurses is upheld.

The possibilities of usefulness which have been opened to the Organisation far exceed the most sanguine hopes of the founders. It soon became evident that the bringing together of scattered organisations and the co-ordination and standardisation of methods was to be only a part of the activity of the National Organisation. Very definite creative work lay before it.

During the first year an executive secretary was engaged, and headquarters secured in New York. Ella Phillips Crandall, a member of the original Joint Committee accepted the position and is still acting in that capacity.

At the end of the first year, Miss Wald resigned the Presidency and became Honourary President. The second President elected in 1913 was Mary S. Gardner, Superintendent of the Providence District Nursing Association. Mary Beard, Director of the Boston Instructive District Nursing Association was elected in 1916 and still holds office.

In addition to the routine work of the Organisation, eleven special standing committees exist, the names being self-explanatory.

Committee on Tuberculosis
Committee on Infant Welfare
Committee on Prevention of Blindness
Committee on School Nursing
Committee on Mental Hygiene
Committee on Industrial Nursing
Committee on Medical Social Service
Committee on Visiting Nursing
Committee on Organisation and Administration
Committee on Public Health Nursing Education
Committee on Records and Statistics.

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